

**Plan Document  
for  
The Conservation Employees'  
Benefits Plan Trust Fund**



**Revision and Re-Statement Date: January 1, 2011**

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## **ADOPTION AGREEMENT**

The Missouri Department of Conservation ("Employer") previously established a health benefits plan (hereafter referred to as "the Plan") providing medical and prescription drug benefits for eligible employees and their dependents in accordance with the terms and conditions of this document ("Plan Document"), effective as of January 1, 2000. The Employer and the Board of Trustees has duly authorized the adoption of this amended and restated Plan and the execution thereof effective on January 1, 2011.

The benefits provided under this Plan and the general terms and conditions governing the same are contained in this Plan Document a copy of which is provided to participants in the Plan, and may also be governed by the provisions of certain insurance contracts purchased on behalf of the Plan. The Plan Document and all such insurance contracts, if any, as the same may be amended from time to time, are hereby incorporated herein by this reference and made a part of this Plan.

Under this Plan, the Employer is the Plan Sponsor, and shall also function as the Plan Administrator and Plan Fiduciary unless another individual or entity is appointed by the Employer. The Plan Sponsor does hereby certify that the Plan Sponsor has reviewed the Plan Document and that it represents the terms and conditions of the Plan adopted by the Plan Sponsor.

## SCHEDULE OF BENEFITS

All benefits described within this Schedule of Benefits are subject to the exclusions and limitations as specifically stated herein including, but not limited to: (a) the Plan Administrator's determination that care and treatment is Medically Necessary; (b) that charges are Reasonable and Customary; and (c) that services, supplies and care are not Experimental or Investigative.

The Plan requires that certain services including, but not limited to hospitalization, be pre-certified. The Plan's pre-certification requirements and penalties for failing to comply with such requirements are described in the section entitled "Pre-Certification Provisions and Case Management."

The Plan offers a broad network of providers within the network selected by the Plan Sponsor. The Plan provides the highest level of benefits when Covered Persons utilize Preferred Providers. Refer to the section entitled "Preferred Provider (PPO) Arrangement" for additional information.

Capitalized words contained within this document are considered to be defined terms. The meanings of such terms can be found in the section entitled "Definitions." The following terms are included in the "Definitions" section of this Plan Document; however, it is important to understand their meanings prior to reading the Schedule of Benefits:

**Copayment** - Means the dollar amount payable by the Covered Person for a service, treatment or procedure rendered. The Copayment is applicable on a per occurrence basis. The Copayment shall continue to apply after the Deductible has been satisfied and after the Out-of-Pocket Limit has been satisfied.

**Deductible** - Means the amount a Covered Person must pay for Eligible Expenses incurred in a Benefit Period before benefits begin to be paid for that person under the Plan.

When applicable, an Individual Deductible is the amount that each Covered Person must pay during a Benefit Period before benefits begin to be paid for that person.

A Family Deductible is the maximum amount that two (2) or more family members covered under the same Family Coverage must pay in Deductible expense in a Benefit Period. Under the Family Deductible, at least two (2) family members must satisfy an amount equal to the Individual Deductible, while Eligible Expenses for all other family members will be used to satisfy the remaining portion of the Family Deductible. Once the Family Deductible is reached, Eligible Expenses incurred with a future date of service within the Benefit Period will not be subject to the Deductible and the Deductible will be considered satisfied for all family members under that Family Coverage during the remainder of the Benefit Period.

**Coinsurance** - Means a percentage of the Provider's Allowable Charge that the Plan pays for Eligible Expenses after the Covered Person's Deductible has been satisfied. The remaining percentage of the Provider's Allowable Charge will be paid by the Covered Person. This percentage of the Provider's Allowable Charge paid by the Covered Person is referred to as the Covered Person's Coinsurance.

**Limitation for Covered Person's Expenses** - Means the maximum amount in Eligible Expenses that are paid at the Coinsurance level as shown in the Schedule of Benefits. Eligible Expenses are payable at the Coinsurance percentages shown in the Schedule of Benefits until the Covered Person has reached the Individual Limitation for Covered Persons Expenses, also shown in the Schedule of Benefits. Once the Covered Person has reached the Individual Limitation for Covered Persons Expenses, Eligible Expenses will be payable at 100% (except for any charges excluded) for the remainder of the Benefit Period.

When the Family Limitation for Covered Persons Expenses is met, Eligible Expenses will be payable at 100% (except for any charges excluded) for the remainder of the Benefit Period for all covered members of the same family.

**Maximum Benefit** – Means the maximum amount the Plan will pay for a given benefit. The Maximum Benefit can be stated as a dollar amount or the maximum number of days or visits for a specific benefit. Refer to the Schedule of Benefits for maximum benefit amounts.

**Should the Covered Person have any questions concerning the benefits contained within this Plan Document, (s)he should contact the Plan Administrator for additional information.  
The Covered Person should verify eligibility for benefits prior to receiving treatment or service.**

**MEDICAL COVERAGE  
SCHEDULE OF BENEFITS**

**Note: The Covered Person is entitled to Medical Benefits only if (s)he has made application for such benefits and been enrolled for Coverage by the Plan Administrator under the Plan.**

COVERED SERVICE/PLAN CATEGORY	HEALTHLINK HMO OR FREEDOM NETWORK SELECT	HEALTHLINK PPO OR FREEDOM NETWORK	OUT-OF-NETWORK **
<b>GENERAL INFORMATION</b>			
<b>Maximum Annual Benefit for Essential Health Benefits</b>	<b>January 1, 2011-December 31, 2011 plan year:</b> \$750,000 <b>January 1, 2012-December 31, 2012 plan year:</b> \$1,250,000 <b>January 1, 2013-December 31, 2013 plan year:</b> \$2,000,000		
<b>Maximum Benefits</b>	All Maximum Benefits, aside from the Maximum Annual Benefit for Essential Health Benefits, are set forth in the Covered Services section of the Schedule of Benefits.		
<b>Deductible*</b> *Once Family Deductible is reached, Eligible Expenses incurred with a future date of service within the Benefit Period will not be subject to the Deductible and the Deductible will be considered satisfied for all family members under that Family Coverage during the remainder of the Benefit Period.	The Covered Person may choose from the following options: <b>Option \$ 750 - Individual Deductible:</b> \$ 750; <b>Family Deductible:</b> \$1,500 <b>Option \$1,250 - Individual Deductible:</b> \$1,250; <b>Family Deductible:</b> \$2,500  <b>Common Accident Provision</b> - If two or more family members are injured in the same accident, family members are required to satisfy only one Individual Deductible for all Eligible Expenses incurred in connection with the accident.  Mo Dept of Conservation does not have an OOP maximum, but a \$7,500 single & \$15,000 Family (2 members need to meet) annual allowed charges threshold. Allowed charges over these thresholds should be paid at 100% for the remainder of the calendar year. This does not include deductible(s), copayments, penalties and charges excluded under the plan.		
<b>Copayment Office Visit</b>	Primary Care Physician (PCP) Office Visit*: \$25 Specialist Office Visit*: \$45  <b>*Copayment applies to all services rendered by same provider in connection with an office visit for which an office visit is billed except for surgery, chemotherapy and radiation therapy.</b>	Primary Care Physician (PCP) Office Visit*: \$25 Specialist Office Visit*: \$45	Not Applicable
<b>Copayments Other</b>	Inpatient Admission: \$150. then Deductible. After the Deductible, the Plan pays 90% Outpatient Surgery: \$75, then Deductible. After the Deductible, the Plan pays 90%	Inpatient Admission: \$150. then Deductible. After the Deductible, the Plan pays 80% Outpatient Surgery: \$75, then Deductible. After the Deductible, the Plan pays 80%	Inpatient Admission: \$150. then Deductible. After the Deductible, the Plan pays 70% Outpatient Surgery: \$75, then Deductible. After the Deductible, the Plan pays 70%
<b>Limitation for Covered Person's Expenses</b>	Individual Limitation for Covered Person's Expenses: \$ 7,500 Family Limitation for Covered Person's Expenses: \$15,000		
<b>Coinsurance</b>	Except as specified in the Covered Services section of the Schedule of Benefits, Plan will pay 90% of Provider's Allowable Charge.	Except as specified in the Covered Services section of the Schedule of Benefits, Plan will pay 80% of Provider's Allowable Charge.	Except as specified in the Covered Services section of the Schedule of Benefits, Plan will pay 70% of Provider's Allowable Charge.

**\*\* Medicare Primary Retirees or Medicare Primary Other Persons benefits will be paid at the Out-of-Network Benefit level. The Plan will then coordinate the benefits with Medicare in accordance with Medicare Secondary Payer rules.**

COVERED SERVICE/PLAN CATEGORY	HEALTHLINK HMO OR FREEDOM NETWORK SELECT	HEALTHLINK PPO OR FREEDOM NETWORK	OUT-OF-NETWORK **
<b>COVERED SERVICES</b>			
This listing of Covered Services appears in alphabetical order to better assist the Covered Person in locating the different benefit allowances for the specific Covered Services.			
<b>Accidental Injury Services - Refer to page 26</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Acupuncture and Acupressure*</b> *Limited as described in Medical Benefits section. <b>Refer to page 26</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Allergy Testing - Refer to page 26</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Allergy Treatment - Refer to page 26</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Ambulance Service - Refer to page 27</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Ambulatory Surgical Facility – Outpatient - Refer to page 27</b> Pre-certification is required for certain ambulatory surgeries. Refer to Pre-certification section.	\$75 copay, then Deductible. After the Deductible, the Plan pays 90%	\$75 copay, then Deductible. After the Deductible, the Plan pays 80%	\$75 copay, then Deductible. After the Deductible, the Plan pays 70%
<b>Anesthesia Services - Refer to page 27</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Bereavement Counseling - Refer to Hospice Services to page 31</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
	1. Services covered under the Plan shall be provided for the deceased's immediate family (Covered Dependents) under this Plan; 2. Services must be rendered within the first 6 months following the loss of the patient; and 3. Services are subject to a Maximum Benefit of 15 visits per Covered Person per lifetime.		
<b>Birth Control Services - Refer to page 27</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Birthing Center Services - Refer to page 27</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Cardiac Rehabilitation Therapy – Outpatient - Refer to page 28</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%

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<b>COVERED SERVICE/PLAN CATEGORY</b>	<b>HEALTHLINK HMO OR FREEDOM NETWORK SELECT</b>	<b>HEALTHLINK PPO OR FREEDOM NETWORK</b>	<b>OUT-OF-NETWORK **</b>
<b>Chemotherapy – Outpatient - Refer to page 28</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Chiropractic Services – Outpatient - Refer to page 28</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Clinical Cancer Trials – Phases II, III, and IV – Refer to page 28</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Dental Services*</b> *Limited as described in Medical Benefits section. <b>Refer to page 29</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Diagnostic Services* - Outpatient</b> *Includes lab, x-rays, interpretations of tests to diagnose Illness or Injury and pre-admission testing. <b>Refer to page 29.</b> Pre-certification is required for certain diagnostic procedures. Refer to Pre-certification section.	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Durable Medical Equipment - Refer to page 30.</b> Pre-certification is required for certain durable medical equipment. Refer to Pre-certification section.	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Emergency Care in Emergency Department of Hospital - Refer to page 30</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 80%
<b>Home Health Care Services - Refer to page 30.</b> Pre-certification is required. Refer to Pre-certification section.	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Hospice Services - Refer to page 31</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%

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<b>COVERED SERVICE/PLAN CATEGORY</b>	<b>HEALTHLINK HMO OR FREEDOM NETWORK SELECT</b>	<b>HEALTHLINK PPO OR FREEDOM NETWORK</b>	<b>OUT-OF-NETWORK **</b>
<b>Hospital Services During Inpatient Confinement - Refer to page 31.</b> Pre-certification is required. Refer to Pre-certification section.	\$150 copay, then Deductible. After the Deductible, the Plan pays 90%	\$150 copay, then Deductible. After the Deductible, the Plan pays 80%	\$150 copay, then Deductible. After the Deductible, the Plan pays 70%
	Benefits are limited to the semi-private room rate. However, the Plan will cover a private room at the semi-private room rate if the Hospital does not provide semi-private rooms, or if there are no semi-private rooms available, or when a private room is deemed to be Medically Necessary.		
<b>Human Papillomavirus (HPV) Vaccinations - Refer to page 32</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Infertility Services*</b> *Limited as described in Medical Benefits section. <b>Refer to page 32</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
	Subject to a Maximum Benefit of \$15,000 per family per lifetime.		
<b>Inhalation (Respiration) Therapy - Outpatient - Refer to page 32</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Kidney Dialysis - Outpatient - Refer to page 32</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Maternity Services*</b> * Limited as described in Medical Benefits section. <b>Refer to page 32</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Medical and Surgical Supplies - Refer to page 33</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Nutritional Counseling -</b> The instructor must be a nutritionist. Nutritional counseling will not be considered for Weight Watchers, Nutri-System, etc. <b>Refer to page 33</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Occupational Therapy Services - Outpatient - Refer to page 33.</b> Pre-certification is required. Refer to Pre-certification section.	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Organ Transplants</b>	Refer to the "Transplant Services" benefit on page 40.		
<b>Orthotics and Initial Orthotic Devices*</b> *Limited as described in Medical Benefits section. <b>Refer to page 34</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%

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<b>COVERED SERVICE/PLAN CATEGORY</b>	<b>HEALTHLINK HMO OR FREEDOM NETWORK SELECT</b>	<b>HEALTHLINK PPO OR FREEDOM NETWORK</b>	<b>OUT-OF-NETWORK **</b>
<b>Patient Education Programs *</b> <b>Refer to page 34</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Physical Therapy Services – Outpatient - Refer to page 34.</b> Pre-certification is required. Refer to Pre-certification section.	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Physician Office Visits for Non-Routine (Sick) Care - Refer to page 34</b>	Primary Care Physician (PCP) Office Visit: After \$25 Copayment*, Plan pays 100% Specialist Office Visit: After \$45 copayment*, Plan pays 100%	Primary Care Physician (PCP) Office Visit: After \$25 Copayment*, Plan pays 100% Specialist Office Visit: After \$45 copayment*, Plan pays 100%	After the Deductible, Plan pays 70%
	<b>*Copayment applies to all services rendered by same provider in connection with an office visit for which an office visit is billed except for surgery, chemotherapy and radiation therapy.</b>		
<b>Physician Visits During Inpatient Hospital Confinement - Refer to page 35</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Podiatry Services*</b> *Limited as described in Medical Benefits section. <b>Refer to page 35</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Private Duty Nursing Services - Refer to page 35</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Prosthetic Appliances - Refer to page 35</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Psychiatric Services - Refer to page 36</b>	<b>Inpatient:</b> After the Deductible, the Plan pays 90%	<b>Inpatient:</b> After the Deductible, the Plan pays 80%	<b>Inpatient:</b> After the Deductible, the Plan pays 70%
	<b>Partial Day:</b> After the Deductible, the Plan pays 90%	<b>Partial Day:</b> After the Deductible, the Plan pays 80%	<b>Partial Day:</b> After the Deductible, the Plan pays 70%
	<b>Outpatient:</b> After the Deductible, the Plan pays 90%	<b>Outpatient:</b> After the Deductible, the Plan pays 80%	<b>Outpatient:</b> After the Deductible, the Plan pays 70%

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COVERED SERVICE/PLAN CATEGORY	HEALTHLINK HMO OR FREEDOM NETWORK SELECT	HEALTHLINK PPO OR FREEDOM NETWORK	OUT-OF-NETWORK **
<b>Radiation Therapy – Outpatient - Refer to page 36</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Routine or Diagnostic Colonoscopy for Covered Persons age 50+ - Refer to page 37</b>	First colonoscopy within a 10-year period: Plan pays 100%  Subsequent colonoscopies within the same 10-year period: After the Deductible, the Plan pays 90%	First colonoscopy within a 10-year period: Plan pays 100%  Subsequent colonoscopies within the same 10-year period: After the Deductible, the Plan pays 80%	First colonoscopy within a 10-year period: Plan pays 100%  Subsequent colonoscopies within the same 10-year period: After the Deductible, the Plan pays 70%
<b>Routine/Well Care For Adult (Including Dependent Child Age 17 and Older) – Refer to page 36</b>	Plan pays 100%	Plan Pay 100%	Plan pays 100%
	<ul style="list-style-type: none"> <li>• Routine physical examination</li> <li>• Screening for abdominal aortic aneurysm - one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked.</li> <li>• Screening and counseling to reduce alcohol misuse - screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.</li> <li>• Aspirin to prevent CVD: men - the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.</li> <li>• Aspirin to prevent CVD: women - the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.</li> <li>• Screening for bacteriuria - screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.</li> <li>• Screening for high blood pressure - screening for high blood pressure in adults aged 18 and older.</li> <li>• Counseling related to BRCA screening - women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.</li> <li>• Screening for breast cancer (mammography) - screening mammography for women with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older.</li> <li>• Chemoprevention of breast cancer - clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.</li> <li>• Interventions to support breast feeding - interventions during pregnancy and after birth to promote and support breastfeeding.</li> <li>• Screening for cervical cancer - screening for cervical cancer in women who have been sexually active and have a cervix.</li> </ul>		

**\*\* Medicare Primary Retirees or Medicare Primary Other Persons benefits will be paid at the Out-of-Network Benefit level. The Plan will then coordinate the benefits with Medicare in accordance with Medicare Secondary Payer rules.**

COVERED SERVICE/PLAN CATEGORY	HEALTHLINK HMO OR FREEDOM NETWORK SELECT	HEALTHLINK PPO OR FREEDOM NETWORK	OUT-OF-NETWORK **
<b>Routine/Well Care For Adult (Including Dependents Age 17 and Older) - Refer to page 36</b>	Plan pays 100%	Plan pays 100%	Plan pays 100%
	<ul style="list-style-type: none"> <li>• Screening for chlamydial infection: non-pregnant women - screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.</li> <li>• Screening for chlamydial infection: pregnant women - screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.</li> <li>• Screening for cholesterol abnormalities: men 35 and older - screening men aged 35 and older for lipid disorders.</li> <li>• Screening for cholesterol abnormalities: men younger 35 - screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.</li> <li>• Screening for cholesterol abnormalities: women 45 and older - screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.</li> <li>• Screening for cholesterol abnormalities: women younger than 45 - screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.</li> <li>• Screening for colorectal cancer - screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.</li> <li>• Screening for depression: adults - screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.</li> <li>• Screening for diabetes - screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.</li> <li>• Counseling for a healthy diet - intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.</li> <li>• Supplementation with folic acid - all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.</li> <li>• Screening for gonorrhea: wp,em - clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors; go to Clinical Considerations for further discussion of risk factors).</li> <li>• Screening for hemoglobinopathies - screening for sickle cell disease in newborns.</li> <li>• Screening for hepatitis B - screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.</li> <li>• Screening for HIV- clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection (go to Clinical Considerations for discussion of risk factors).</li> <li>• Screening for iron deficiency anemia - routine screening for iron deficiency anemia in asymptomatic pregnant women.</li> <li>• Screening and counseling for obesity: adults - clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.</li> </ul>		

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COVERED SERVICE/PLAN CATEGORY	HEALTHLINK HMO OR FREEDOM NETWORK SELECT	HEALTHLINK PPO OR FREEDOM NETWORK	OUT-OF-NETWORK **
<b>Routine/Well Care For Dependents (From Birth to Age 17) - Refer to page 37</b>	Plan pays 100%	<ul style="list-style-type: none"> <li>Plan pays 100%</li> </ul>	Plan pays 100%
	<ul style="list-style-type: none"> <li>Routine physical examination,</li> <li>Chemoprevention of dental caries - primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.</li> <li>Screening for depression: adolescents - screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.</li> <li>Prophylactic medication for gonorrhea: newborns - prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.</li> <li>Screening for hearing loss - screening for hearing loss in all newborn infants.</li> <li>Screening for hemoglobinopathies - screening for sickle cell disease in newborns.</li> <li>Screening for congenital hypothyroidism - screening for congenital hypothyroidism (CH) in newborns.</li> <li>Iron supplementation in children - routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia (go to Clinical Considerations for a discussion of increased risk).</li> <li>Screening and counseling for obesity: children - clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.</li> <li>Screening for PKU - screening for phenylketonuria (PKU) in newborns.</li> <li>Screening for visual acuity in children - screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.</li> <li>USPSTF recommended immunizations</li> </ul>		
<b>Skilled Nursing Facility Services - Refer to page 37</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Speech Therapy – Outpatient - Refer to page 38</b> Pre-certification is required. Refer to Pre-certification section.	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Shingles Vaccination (Zostavax) - A single dose of shingles vaccine is indicated for adults 60 years of age and older.</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%

\*\* Medicare Primary Retirees or Medicare Primary Other Persons benefits will be paid at the Out-of-Network Benefit level. The Plan will then coordinate the benefits with Medicare in accordance with Medicare Secondary Payer rules.

<b>COVERED SERVICE/PLAN CATEGORY</b>	<b>HEALTHLINK HMO OR FREEDOM NETWORK SELECT</b>	<b>HEALTHLINK PPO OR FREEDOM NETWORK</b>	<b>OUT-OF-NETWORK **</b>
<b>Substance Abuse Services - Refer to page 38</b>	<b>Inpatient:</b> After the \$150 copay and Deductible, the Plan pays 90%	<b>Inpatient:</b> After the \$150 copay and Deductible, the Plan pays 80%	<b>Inpatient:</b> After the \$150 copay and Deductible, the Plan pays 70%
	<b>Partial Day:</b> After the Deductible, the Plan pays 90%	<b>Partial Day:</b> After the Deductible, the Plan pays 80%	<b>Partial Day:</b> After the Deductible, the Plan pays 70%
	<b>Outpatient:</b> After the Deductible, the Plan pays 90%	<b>Outpatient:</b> After the Deductible, the Plan pays 80%	<b>Outpatient:</b> After the Deductible, the Plan pays 70%
<b>Surgical Services - Refer to page 38.</b> Pre-certification is required for certain surgical procedures. Refer to Pre-certification section.	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Surgical Opinions – Second and Third – Refer to page 38</b>	Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>TMJ Treatment - Outpatient*</b> *Limited as described in Medical Benefits section. Refer to page 39	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Transplant Services – Refer to page 40</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Urgent Care Services in Urgent Care Facility - Refer to page 40</b>	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
<b>Wigs*</b> *Limited as described in Medical Benefits section. Refer to page 40	After the Deductible, the Plan pays 90%	After the Deductible, the Plan pays 80%	After the Deductible, the Plan pays 70%
	1. Subject to a Maximum Benefit of \$200 per Covered Person per Benefit Period; and 2. Subject to a Maximum Benefit of \$3,200 per Covered Person per lifetime.		

**\*\* Medicare Primary Retirees or Medicare Primary Other Persons benefits will be paid at the Out-of-Network Benefit level. The Plan will then coordinate the benefits with Medicare in accordance with Medicare Secondary Payer rules.**

<b>PRESCRIPTION DRUG COVERAGE SCHEDULE OF BENEFITS</b>	
<b>Note: The Covered Person is entitled to Prescription Drug Benefits only if (s)he has made application for such benefits and been enrolled for Coverage by the Plan Administrator under the Plan.</b>	
<b>Covered Services</b>	<b>Copayment Amount and Supply Limitation</b>
<b>PHARMACY</b>	
Generic Drug	\$15 or lesser of
Formulary Brand Name Drug	\$30 or lesser of
Non-Formulary Brand Name Drug	\$50 or lesser of
Maximum Day Supply per Prescription	30-day supply
<b>MAIL ORDER</b>	
Generic Drug	\$30
Formulary Brand Name Drug	\$60
Non-Formulary Brand Name Drug	\$100
Maximum Day Supply per Prescription	90-day supply
<b>SPECIALTY PHARMACY</b>	
Specialty Drug	20% up to a maximum of \$150
Maximum Day Supply per Prescription	30-day supply

The Plan offers a generic drug feature. This feature covers specific generic drugs as listed below. Covered Persons must consult with their Physician to determine the appropriateness of the generic drug. If the Physician agrees the alternative drug is acceptable, the Physician must give the Covered Person a prescription written for the alternative drug. Covered Persons can use this feature any time during the Benefit Period.

For the following alternative generic drugs, the Plan will waive the Copayment for the first fill. All future refills will be subject to the applicable generic drug Copayment.

<b>ALTERNATIVE GENERIC DRUGS</b>		
<b>Health Conditions</b>	<b>Current Prescription Drug</b>	<b>Generic Alternative</b>
High Cholesterol	Crestor 5mg, Lipitor 10mg or 20mg	Simvastatin/generic Zocor, Lovastatin, Pravastatin
Seasonal Allergy	Nasonex, Nasocort, Rhinocort	Fluticasone nasal spray/generic Flonase

For the following two alternative generic drugs, Omeprazole and Loratadine will have a \$0 copay for all fills of the medication.

<b>ALTERNATIVE GENERIC DRUGS</b>		
<b>Health Conditions</b>	<b>Current Prescription Drug</b>	<b>Generic Alternative</b>
Gastric Ulcer, Gastritis	Aciphex, Nexium, Prevacid, Prilosec, Protonix	Omeprazole
Seasonal Allergy	Alavert, Allegra-D, Clarinex-D, Singulair, Xyzal, Zyrtec	Loratadine

## **ELIGIBILITY PROVISIONS**

### **ELIGIBLE EMPLOYEES**

Employees must meet the following eligibility requirements in order to be considered an Eligible Employee:

1. The employee must be in a salary exempt or salary non-exempt position
2. The employee must be Actively at Work on the date coverage begins; and
3. The employee must make the required contribution towards the coverage.

In addition the following classes of employees are eligible for Coverage under this Plan and shall have the same rights as any other Eligible Employee (e.g., COBRA, HIPAA Special Enrollment Rights, etc.):

1. A person who is appointed to the Conservation Commission by the Governor, by and with the consent of the Senate;
2. A Full-Time Job Share Active Employee of the Employer who normally works at least 20 hours per week;
3. Retired members of the Conservation Commission;
4. Eligible Retired Employees of the Employer who were covered under the Plan's active benefits prior to retirement; and
5. Appointed active and retired members of the Conservation Commission beginning June 1, 2002.

### **ELIGIBLE DEPENDENTS**

The following persons are considered to be Eligible Dependents:

1. The spouse of the Covered Employee. As used herein, "spouse" includes individuals of the opposite sex only and does not include a domestic partner. The Plan does not recognize common law marriages. For eligibility purposes, the Plan Administrator requires documentation proving a legal marital relationship.
2. A Dependent Child of a Covered Employee or Covered Employee's Covered Spouse. Under the Plan, a Dependent Child is:
  - a. A child who is the Employee's natural child, step child, foster child, legally adopted child or who is under the Employee's legal guardianship pursuant to an interlocutory order of adoption and who is under age 18 at time of placement (Coverage eligibility begins from time of placement in the home for adoption if a petition for adoption is filed within 30 days of placement of such child) and under the Dependent Limiting Age.

As used herein, the Dependent Limiting Age shall mean the date on which the child attains the age of 26,

- b. A child who is dependent pursuant to a Qualified Medical Child Support Order ("QMCSO") as set forth under The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) will be considered a Dependent Child under this Plan. The QMCSO entitles such child to Coverage even if (a) such child does not reside with the Covered Employee or is not dependent on the employee for support, and (b) even if the employee does not enroll for Coverage under the Plan or does not have legal custody of the child. If the Eligible Employee has not satisfied the applicable Waiting Period, the Plan must cover the Dependent Child upon the Eligible Employee's completion of such Waiting Period. All other applicable enrollment provisions of the Plan (e.g., Dependent Limiting Age, benefit options, right to continued Coverage, etc.) which are available to Covered Employees or other Covered Dependents shall be made available to the Dependent Child who is eligible pursuant to a Qualified Medical Child Support Order;

- c. An unmarried child who is over the Dependent Limiting Age of the Plan and otherwise meets the definition of a Dependent Child and who is permanently disabled upon attainment of the Dependent Limiting Age. The Dependent Child must be incapable of self-sustaining employment by reason of mental retardation or mental or physical disability and primarily dependent upon the Covered Employee for support and maintenance. The Covered Employee must make application for continuation of Coverage to the Plan within 31 days after the Dependent Child reaches the Dependent Limiting Age. Such application shall include proof satisfactory to the Plan of the Dependent Child's incapacity and dependence upon the Covered Employee;

**Note:** If both a husband and a wife are covered under this Plan as Employees of the Missouri Department of Conservation, an eligible Dependent Child may only be enrolled under one parent's Coverage under this Plan. The Plan will not provide benefits to a Dependent Child under both the husband and the wife when both are employed by the Missouri Department of Conservation; and

3. A Surviving Spouse and Dependent Children who are covered under the Plan at the time of the Covered Employee's death.

The Plan Administrator has the right to request information needed to determine the patient's eligibility when a claim is filed. In addition, the Plan Administrator has the right to request that the Covered Employee provide proof of the continuance of the incapacity and dependence of any Dependent Child who is permanently disabled.

#### **ELIGIBILITY DETERMINATIONS UNDER HIPAA**

Federal Law, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), prohibits the Plan Sponsor from denying Coverage under the Plan based on any of the following health-related factors:

1. Health status;
2. Medical condition (including both physical and mental illnesses);
3. Receipt of healthcare;
4. Medical history;
5. Genetic information;
6. Evidence of insurability (including conditions arising out of acts of domestic violence); and
7. Disability.

## **APPLYING FOR COVERAGE AND EFFECTIVE DATES**

### **ENROLLMENT PERIOD FOR NEW HIRES AND REHIRES**

For Eligible Employees who are newly hired, re-hired or become eligible under the Plan, the Eligible Employee must complete and submit an enrollment application to the Plan within 31 days of the Eligible Employee's official date of employment. Coverage shall become effective on the 1<sup>st</sup> or the 16<sup>th</sup> of the month following the Eligibility Period. As used herein, the Eligibility Period is one month from the Eligible Employee's official date of employment.

In addition to an enrollment application, an Eligible Employee must submit proof that the Employee and any Eligible Dependent(s) are citizens or permanent residents of the United States or are lawfully present in the United States. This proof may take the form of:

- US Birth Certificate
- U.S. Passport (valid or expired)
- U.S. Passport Card (valid or expired)
- Certificate of Citizenship
- Certificate of Birth Abroad
- Certificate of Naturalization
- Valid Lawful Permanent Resident Card

An Eligible Employee and any Eligible Dependent(s) who cannot provide the proof required may alternatively sign an affidavit under oath, attesting to either United States citizenship or classification by the United States as an alien lawfully admitted for permanent resident, in order to receive temporary benefits or a temporary identification document. The affidavit shall be on or consistent with forms prepared by the state or local government agency administering the state or local public benefits and shall include the applicant's Social Security number or any applicable federal identification number and an explanation of the penalties under state law for obtaining public assistance benefits fraudulently.

If the Eligible Employee and/or Eligible Dependent(s) have provided the sworn affidavit, they will be eligible to receive temporary public benefits for:

- 90 days or until such time that it is determined that the Eligible Employee and/or Eligible Dependent(s) are not lawfully present in the United States, whichever is earlier; or
- Indefinitely if the Eligible Employee and/or Eligible Dependent(s) provides a copy of a completed application for a birth certificate that is pending in Missouri or some other state. An extension granted under this provision shall terminate upon receipt of a birth certificate or a determination that a birth certificate does not exist because the Eligible Employee and/or Eligible Dependent(s) are not a United States citizen.

All Eligible Employees and/or Eligible Dependent(s) must have the appropriate documentation presented at the time of application. A copy of the following documentation is needed:

- Employee – Birth Certificate
- Marriage – Marriage License
- Dependent(s) – Birth Certificates for each person added
- Divorce – Divorce Decree
- Birth – Birth Certificate
- Adoption – Adoption Papers
- Certificate of Creditable Coverage

If an Eligible Employee is not Actively Working on the day Coverage would otherwise become effective, the Effective Date of Coverage will be postponed to the day the Eligible Employee returns to work. This does not apply if the Eligible Employee is not Actively Working due to the existence of a health condition.

## SPECIAL ENROLLMENT PERIODS

There are a number of circumstances that qualify as Special Enrollment Periods. The following events qualify as Special Enrollment Periods under the Plan:

1. **Loss of Other Coverage:** Eligible Employees who decline enrollment when initially eligible under the Plan, and subsequently lose coverage under another plan, may complete and submit an application within 31 days following the termination of other coverage. The effective date under the Plan will begin the day following the loss of other coverage, as set forth below. In this event, loss of coverage must be due to:
  - a. Exhaustion of COBRA benefits;
  - b. Loss of Eligibility under the prior coverage; or
  - c. Termination of contributions by the employer under the prior plan.

This Special Enrollment Period also applies to Dependents of Eligible Employees who decline enrollment when initially eligible under the Plan. The enrollment form must be accompanied by adequate documentation to substantiate the loss of coverage. This documentation must also indicate the reason for termination of coverage.

2. **Birth or Adoption:** In the event of a birth of a child or adoption or placement for adoption of a child, the newly acquired child and the Eligible Employee and spouse, if not covered, will be eligible to enroll for Coverage under this provision. In this event, application must be completed and submitted to the Plan within 31 days following the date the dependent child becomes an Eligible Dependent. Coverage shall be made effective on the birth date the child, or for an adopted child or child placed for adoption, on the date the Dependent Child becomes an Eligible Dependent. In this instance, in addition to the newly acquired Dependent Child under this provision, the Eligible Employee and the spouse, who are otherwise eligible under the Plan, and who did not enroll under the Plan when initially eligible or during a subsequent open enrollment period, if applicable, are permitted to enroll during this special enrollment period.
3. **Marriage:** In the event Covered Employee marries after his or her Coverage has become effective, the employee may add his or her spouse to the Coverage by completing and submitting to the Plan an application within 31 days of the event. In this event, Coverage will be effective on date of the marriage. In this instance, the Eligible Employee who is otherwise eligible under the Plan, and who did not enroll under the Plan when initially eligible or during a subsequent open enrollment period, if applicable, and any Dependent child(ren) who is/are acquired as the result of the marriage, are permitted to enroll during this special enrollment period.
4. **Special Enrollment for Previously Enrolled Covered Persons:** Dependents who had ceased to be eligible to enroll in the Plan prior to the passage of the Patient Protection and Affordable Care Act shall be provided with a 30 day special enrollment opportunity. This special enrollment opportunity will begin January 1, 2011. All dependents whose coverage under this Plan had previously ended, or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before age 26, are eligible to enroll, or re-enroll in the Plan or coverage under this special enrollment period. Coverage for dependents who enroll through this special enrollment opportunity must take effect no later than January 1, 2011.

Covered persons who were previously enrolled, but were terminated from Plan participation because of a prior lifetime limitation provision shall be provided with a 30 day special enrollment opportunity. This special enrollment opportunity will begin January 1, 2011. All covered persons whose coverage under this Plan had previously ended, or who were denied coverage (or were not eligible for coverage) because the prior lifetime limitation had been reached, are eligible to enroll, or re-enroll in the Plan or coverage under this special enrollment period. Coverage for covered persons who enroll through this special enrollment opportunity must take effect no later than January 1, 2011.

## **ENROLLMENT PERIOD FOR SURVIVING SPOUSE AND DEPENDENT CHILDREN**

The Plan provides continuation of coverage for Surviving Spouses and Dependent Children who are covered under the Plan at the time of the Covered Employee's death. In order to continue Coverage under the Plan, an application must be completed and submitted within 60 days following the Covered Employee's death.

## **LATE ENROLLMENT**

Employees or Dependents who fail to submit an enrollment application during the time periods set forth above will be considered Late Enrollees. Late Enrollees will be permitted to enroll for Coverage during the Plan's Open Enrollment Period.

## **OPEN ENROLLMENT PERIOD**

Except as set forth in the ELIGIBLE DEPENDENTS section and as may be required by the Patient Protection and Affordable Care Act, the Plan does not provide an annual open enrollment period. In order to enroll for Coverage under the Plan, Eligible Employees and Dependents who did not enroll for Coverage when initially eligible must have a qualifying event as outlined in the section entitled "Special Enrollment Periods".

## **PRE-EXISTING CONDITION WAITING PERIOD**

The Plan has a 12-month Pre-Existing Condition Waiting Period for all Covered Persons who are aged 19 or older. Coverage will not be provided for a Pre-Existing Condition until the waiting period has elapsed. Except as set forth below, the Pre-Existing Condition Waiting Period applies to all persons covered under the Plan and begins on the Covered Person's Enrollment Date. Any Covered Person who has not yet reached the age of 19 is not subject to the pre-existing condition limitation(s) described herein.

The Pre-Existing Condition Waiting Period will be reduced by number of days the individual was covered under any Creditable Coverage in effect prior to his or her Enrollment Date, provided there is not a Significant Break between the Enrollment Date and the termination date of the Creditable Coverage.

As used in the Plan Document, a Pre-Existing Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the Covered Person's Enrollment Date. A pregnancy is not considered a Pre-Existing Condition.

## TERMINATION PROVISIONS

### TERMINATION OF EMPLOYEE COVERAGE

Coverage will terminate for the Covered Employee and his/her Covered Dependents on the earliest of the following:

1. The date the Plan terminates;
2. The date the Covered Employee's eligible class, as outlined in the section entitled "Eligible Employees" is eliminated;
3. The day the Covered Employee ceases to be in one of the eligible classes, as outlined in the section entitled "Eligible Employees." This includes death and termination of active employment; or
4. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees have not been submitted when due.

Coverage under the Plan shall terminate at midnight on the day of the month when any of the above named instances occur.

**Insurance premiums are payroll deducted on the 15<sup>th</sup> and last day of the month. The Plan does not pro-rate any portion of the premium.**

The employee may be eligible for continued Coverage under COBRA or another Continued Coverage option as described in the section entitled "Continuation of Coverage."

### TERMINATION OF DEPENDENT COVERAGE

Coverage will terminate for the following Covered Person(s) on the earliest of the following:

1. The date the Plan terminates;
2. The date the Employee's Coverage terminates;
3. The date of the Employee's death, unless the Covered Spouse and/or Dependent Child is eligible as a Surviving Spouse and/or Dependent Child of such Spouse. Refer to the section entitled "Termination of Surviving Spouse and Dependent Child Coverage;"
4. The date a Dependent loses dependency status under the Plan;
5. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees have not been submitted when due.

Coverage under the Plan shall terminate at midnight on the day of the month when any of the above named instances occur. **The Plan does not pro-rate any portion of the premium.**

The **Covered Spouse and/or Dependent Child** may be eligible for continued Coverage under COBRA or another Continued Coverage option as described in the section entitled "Continuation of Coverage."

### TERMINATION OF SURVIVING SPOUSE AND DEPENDENT CHILD COVERAGE

Coverage will terminate for the following Covered Person(s) on the earliest of the following:

1. The date the Plan terminates;
2. The date the Employer terminates Coverage for Surviving Spouses and their Dependent Children;
3. The date a Dependent Child loses dependency status under the Plan;
4. The date the Surviving Spouse remarries or obtains other coverage; or
5. The end of the period for which any required contribution by the Employer or Surviving Spouse has been made if payment of fees have not been submitted when due.

Coverage under the Plan shall terminate at midnight on the day of the month when any of the above named instances occur.

**Insurance premiums are deducted monthly from the MOSERS retirement check or invoiced quarterly if there are not enough funds to pay the monthly premium. The Plan does not pro-rate any portion of the premium.**

The **Covered Spouse and/or Dependent Child** may be eligible for continued Coverage under COBRA or another Continued Coverage option as described in the section entitled "Continuation of Coverage."

#### **CONTINUED COVERAGE FOLLOWING EMPLOYER-APPROVED LEAVE OF ABSENCE (OTHER THAN FMLA)**

In the event the Covered Employee temporarily ceases to be Actively Employed due to an employer-approved leave of absence, Coverage will continue in place for a period of one year until the employee's return to Active Employment. The Covered Employee is only eligible under this provision if his or her leave of absence or disability is considered temporary, the employee continues to remain in the employ of the Employer, (s)he continues to receive employee-related benefits and (s)he continues to make any contributions as may be required by the Employer. While continued, Coverage will be the same as that which was in force on the last day worked while Actively Employed. However, if benefits are reduced for others in this class of employees, such benefits will also be reduced for the Covered Employee and any Eligible Dependents who are on continuing coverage due to an employer-approved leave of absence.

Contact the Employer or Plan Sponsor to determine how this FMLA provision impacts the Employer's paid sick leave or leave of absence policy.

#### **CONTINUED COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)**

Under the Family and Medical Leave Act of 1993 ("FMLA"), an employer who is subject to FMLA requirements must provide to the employee unpaid leave of absence. For details of the provisions of the FMLA, the Covered Employee should contact the Human Resources Division of the Missouri Department of Conservation.

#### **CONTINUED COVERAGE FOR EMPLOYEES IN UNIFORMED SERVICES**

In the event the Covered Employee is required to be absent from work as the result of service in the Uniformed Services, Coverage for Medical Benefits may be continued for the Covered Employee in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

As used herein, Uniformed Services means the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

### **Period of Continued Coverage Under the USERRA Provision**

Coverage may be continued for the Covered Employee and his or her covered Dependents for a period which shall equal the lesser of the following:

1. The 24-month period beginning on the date on which the employee's absence begins; or
2. The period beginning on the date on which the employee's absence begins and ending on the day after the date on which the employee fails to apply for or return to a position of employment.

### **Notification and Election**

The Covered Employee must notify the Employer in writing and submit to the Employer the entire monthly payment, as such may be applicable, if he or she wishes to continue Coverage. The Covered Employee's election and first month's monthly payment is due at the earliest of the following:

1. If the Employer notifies the Covered Employee of his or her right to continue Coverage before Coverage would otherwise end, then the Covered Employee's election and monthly payment must be submitted to the Employer no later than 31 days after the date the Covered Employee's Coverage would have otherwise terminated.
2. If the Employer notifies the Covered Employee of his or her right to continue Coverage after Coverage has terminated, then the Covered Employee's election and monthly payment must be submitted within 31 days following the date of notification by the Employer.

### **Cost of Continued Coverage**

The Employer may require the Covered Employee or Dependent to pay the full cost of the continued Coverage. The monthly payment may not exceed 102% of the monthly payment being charged by the Employer for similarly situated employees. However, if the employee performs service in the Uniformed Services for less than 31 days, such employee may not be required to pay more than 100% of the monthly payment being charged by the Employer for similarly situated employees.

### **Termination of Continued Coverage**

The continuation of Coverage ends at the earliest of the following:

1. When the Covered Person becomes covered under another group health plan without pre-existing condition limitation;
2. Upon the expiration of the continued period of Coverage as set forth herein;
3. When the required payments are not received on a timely basis;
4. When the health plan is terminated and not replaced by the Employer with another health plan.

<p><b>**For information regarding COBRA, please refer to the section entitled, "COBRA Continuation of Coverage."</b></p>
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## MEDICAL BENEFITS

This section describes the Covered Person's Medical Benefits. The Plan will cover the Medical Benefits when services:

1. Are authorized by a Physician;
2. Are rendered and billed by a Provider;
3. Qualify as a Covered Service; and
4. Are Medically Necessary, except as specified.

For Medical Benefits, payment of the Provider's Allowable Charge, or the actual charge, whichever is less, will be provided for all Covered Services. With respect to the Preferred Providers, the Provider's Allowable Charge will be based on the Negotiated Rate set forth in the PPO contract. For a Non-Preferred Providers, the Provider's Allowable Charge will be the Customary and Reasonable Charge.

All payments will be subject to any applicable Copayments, Deductible, Coinsurance, maximum benefits and other provisions and limitations in this Plan Document and the Schedule of Benefits. All benefit payments will be made based on the procedure code assigned by the Provider for the specific procedure or service rendered and billed by that Provider.

## PRE-CERTIFICATION PROVISIONS AND CASE MANAGEMENT

The Plan requires that the Covered Person obtain pre-certification in advance of receiving certain services. In addition, the Plan has a separate requirement that requires that the Covered Person provide notification following a Hospital Admission when such admission is not scheduled and occurs through the Emergency Room or Department of a Hospital. These requirements are described in detail in this section of the Plan Document.

The purpose of these pre-certification and notification requirements is to assist the Plan in determining the Medical Necessity of the services or procedures and the appropriateness of the planned course of treatment (e.g., appropriate length of stay or the appropriate number of visits or treatments). Compliance with the pre-certification and notification requirements is not a guarantee of benefit payment.

Under the Plan, a utilization review administrator will conduct and manage the pre-certification and notification process for a non-scheduled admission. This means that the Covered Person should contact the utilization review administrator at the telephone number appearing on the identification card to facilitate this process. In each instance, the Covered Person may satisfy this requirement by having the Hospital, Admitting Physician or a family member contact the utilization review administrator to provide the required pre-certification or notification.

### Pre-Certification for Scheduled Admissions

Pre-Certification must be obtained for every **scheduled** Hospital Admission. There are different notification and/or pre-certification requirements for non-scheduled Hospital admissions.

In an order to obtain pre-certification, the Covered Person should contact the utilization review administrator when there is a scheduled Hospital admission within 10 business days prior to the admission. When pre-certification is provided, a certain number of Inpatient Hospital days for the stay will be assigned. If the Covered Person fails to follow the pre-certification guidelines as set forth herein, payment of benefits for Hospital expenses will be reduced by \$200 (called penalty). This penalty will be applied prior to any applicable Copayment, Deductible or Coinsurance. If services are not Medically Necessary, no benefits are payable at all. This out-of-pocket amount may not be used to satisfy any Out-of-Pocket Expense Limits.

**Special Note About Confinements for Maternity Services:** Pre-Certification of Hospital admissions for Maternity Services is not required for any Hospital Confinement for such services unless the Confinement exceeds 48 hours for a routine vaginal delivery and 96 hours for a cesarean section delivery.

### **Notification for Non-Scheduled Admission**

If a Covered Person is admitted to a Hospital for a non-scheduled admission, notice of the admission must be provided to the utilization review administrator no later than 48 hours after the admission. The admission will be reviewed within 1 working day of the date notification of the admission has been provided. The review will be performed with the Covered Person's Physician to determine if a continued Hospital stay is Medically Necessary. Failure to provide notice of a Covered Person's non-scheduled admission will result in a \$200 reduction (called penalty) in the payment for Hospital Eligible Expenses.

A non-scheduled admission is an emergency or unplanned admission to the Hospital. Non-scheduled admissions frequently occur through the emergency department of a Hospital. The Plan will **not** provide coverage for non-Medical Emergency Hospital admissions which occur on a Friday or Saturday unless surgery is performed within 24 hours of the Hospital admission.

### **Pre-Certification for Additional Admissions/Procedures**

In addition to receiving pre-certification for scheduled and non-scheduled Hospital admissions, the Covered Person is required to obtain pre-certification for the following admissions, procedures, services and supplies:

#### **Inpatient Services**

- Skilled Nursing Facility Admissions
- Rehabilitation Facility Admissions
- LTAC Admissions
- Lumbar Spine Surgery

#### **Surgical Procedures – Ambulatory**

- Nasal Septoplasty
- Rhinoplasty
- Cartilage Transplant Knee
- Lumbar Spine Surgery
- Sleep Apnea Surgery – LAUP/UPPP, Nasal and Uvulopalatoplasty
- Sinus Endoscopy

#### **Ancillary Services – Ambulatory**

- Physical therapy
- Speech therapy
- Occupational therapy
- Home infusion service
- Home health care services

#### **Durable Medical Equipment**

- Tens Units
- Neuromuscular Stimulators
- Functional Electrical Stimulators
- Bikes
- Custom Wheelchairs
- Power Wheelchairs
- Cooling Devices (e.e. Polar Care)
- Cochlear Implant

- Bone Stimulator
- Wound Vacs
- Electric Scooters
- Cardio/External Defibrillator
- Myoelectric Prosthetics
- CPAP/BIPAP
- Limb Prosthetics

#### Diagnostic Imaging – Ambulatory

- MRA of the Head and/or Neck
- MRI of the Brain
- MRI of Spine – Cervical, Thoracic, Lumbar, Sacral
- PET Scans

In order to obtain pre-certification, the Covered Person should contact the utilization review administrator within 10 business days prior to obtaining or receiving these procedures, services or supplies. A Covered Person must contact the utilization review administrator within 48 hours after an unscheduled Hospital admission for these procedures, services or supplies. If the Covered Person fails to follow the pre-certification guidelines as set forth herein, payment of benefits for all related charges will be reduced by \$200 (called penalty). This penalty will be applied prior to any applicable Copayment, Deductible or Coinsurance. If services are not Medically Necessary, no benefits are payable at all. This out-of-pocket amount may not be used to satisfy any Out-of-Pocket Limit.

### **Continued Stay Review and Discharge Planning**

During a Covered Person's Hospital stay, a Continued Stay Review will be conducted. This review applies to all Hospital admissions. The purpose of Continued Stay Review is to enable the Health Plan to re-evaluate the Medical Necessity of a continued Hospital stay. It may be necessary to obtain additional information concerning the Covered Person's Hospital stay in order to conduct a Continued Stay Review.

Review for Discharge Planning occurs during Hospitalization Review. The purpose is to identify patients requiring extended care following discharge and determine the most appropriate setting for continued care.

### **Case Management**

Case Management is a voluntary program and it is designed to inform patients of more cost effective settings for treatment. Case Management typically applies when an individual has a chronic or ongoing condition, or a catastrophic condition, that is expected to result in significant claim costs for the Plan. In this event, on an exception basis, benefits may be provided for settings and/or procedures not expressly covered under the Plan, if the setting and/or procedure will assist the Plan Sponsor in managing the Plan's medical costs. All requests for Case Management will be individually reviewed by the Plan.

If a Covered Person requests an alternative setting or procedure under Case Management, the Plan Sponsor has the right to deny Coverage for such setting or procedure and benefits pursuant to the terms of the Plan, exclusive of this provision.

Case Management Program shall mean a program, which provides for a nurse case manager to coordinate the medical services required by a Participant in the event such Participant, suffers a serious Sickness or Injury which involves ongoing care or Hospital Confinement. The nurse case manager shall explore with the Participant; such Participant's Family and the treating Physician, the availability and feasibility of possible alternative treatment plans.

## **PREFERRED PROVIDER ORGANIZATION (PPO) ARRANGEMENT**

The Plan offers a broad network of providers within the HMO Network and PPO Network selected by the Plan Sponsor. The Plan provides the highest level of benefits when Covered Persons utilize Preferred Providers within the HMO Network. The Plan also provides a high level of benefits when a Covered Person utilizes Preferred Providers within the PPO Network. Preferred Providers are those who are contracted with the network indicated on the identification card. Services provided by Non-Preferred Providers will generally be covered at a lower benefit level than services received from a Preferred Provider. Preferred Providers must accept a reduced rate ("Negotiated Rate") as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate. With respect to the Preferred Providers, the payment will be based on the Negotiated Rate set forth in the PPO contract. For a Non-Preferred Provider, the payment will be the Customary and Reasonable Charge. However, with respect to dialysis-related services and products, payment is based on an alternative basis as described in the following paragraph.

With respect to covered dialysis-related services and products provided on an Outpatient basis ("Outpatient Dialysis"), the Plan applies an alternative basis of payment in connection with Outpatient Dialysis claims. This alternative basis may be applied to claims by any Provider, regardless of the Provider's participation in a network. This alternative basis is based on the Outpatient Dialysis Usual and Reasonable Charge, as defined herein. The Plan shall pay no more than the Outpatient Dialysis Usual and Reasonable Charge, after deduction of all amounts subject to Deductible, Coinsurance, or applicable Copayments. Refer to the benefit description of Kidney Dialysis for further details.

**No Choice of Provider** - If, while receiving covered treatment in a Network facility, a Covered Person receives ancillary services from a non-Preferred provider in a situation in which he has no control over provider selection (such as in the selection of an emergency room Physician, an anesthesiologist, radiologist pathologist, consulting physician or a provider for other diagnostic services), such non-Network services will be covered at the PPO benefit level.

## **COVERED SERVICES**

The following services are those Covered Services under the Plan. The list of services appears in alphabetical order.

### **Accidental Injury**

The Plan will cover Injuries that are the direct result of an accident when such services are rendered by a Physician, Hospital or Other Provider.

### **Acupuncture and Acupressure**

The Plan will cover acupuncture and acupressure services when such services are rendered by a Physician, Hospital or Other Provider and are deemed Medically Necessary.

### **Acute Rehabilitation Facility**

The Plan will cover certain services when the Covered Person is confined as an Inpatient in an Acute Rehabilitation Facility for the care and treatment of an Illness or Injury requiring acute rehabilitation services. The following room and board expenses and ancillary services will be covered:

1. **Room and Board.** Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services. Coverage includes a bed in a special care unit approved by the Plan. Use of a private room will be covered at the facility's semi-private room rate if the Hospital does not provide semi-private rooms, or if there are no semi-private rooms available, or when a private room is deemed to be Medically Necessary;
2. **Ancillary Services.** Ancillary Services received during a Confinement in an Acute Rehabilitation Facility include, but are not limited to:
  - a. Treatment rooms and equipment used therein;
  - b. Prescribed drugs;
  - c. Medical and surgical dressings, supplies, casts and splints;
  - d. Blood, blood transfusions and other blood-related services;
  - e. Diagnostic Services;
  - f. Inhalation therapy;
  - g. Physical Therapy;
  - h. Occupational Therapy; and
  - i. Speech Therapy.

**Note:** Pre-certification must be obtained for Acute Rehabilitation Facility admissions. Refer to the section entitled "Pre-Certification Provisions and Case Management" for details.

### **Allergy Treatment and Testing**

The Plan will cover allergy injections, the serum and allergy testing when such services are performed by a Physician.

## **Ambulance Service**

Ambulance service is transportation by a vehicle designed, equipped and used only to transport the sick and injured:

1. From the Covered Person's home, scene of accident or medical emergency to a Hospital;
2. Between Hospitals;
3. Between Hospital and Skilled Nursing Facility; or
4. From a Hospital or Skilled Nursing Facility to the Covered Person's home.

Surface trips must be to the closest local facility that can give Covered Services appropriate for the Covered Person's condition. If none, the Covered Person is covered for trips to the closest such facility outside his/her local area.

Air transportation is only covered when such transportation is Medically Necessary because of a life threatening Injury or Illness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for Inpatient care.

## **Ambulatory Surgical Facility Services**

The Plan will cover services rendered and billed by an Ambulatory Surgical Facility in connection with the performance of a covered surgical procedure performed in such facility.

## **Anesthesia Services**

The Plan will cover the administration of anesthesia by a Physician or Other Medical Professional Provider who is not the surgeon or assistant at surgery for surgery performed by a Physician on an Inpatient or Outpatient basis.

## **Birth Control**

The Plan will cover the injections (including the injection of Depo Provera), contraceptive devices, the insertion of intrauterine devices (IUDs) and the surgical removal of IUDs when performed by a Physician or Other Medical Professional Provider.

## **Birthing Center Services**

The Plan will cover the following services in connection with Maternity Services provided to a Covered Person when such services are rendered and billed by a Birthing Center:

1. Operating room and equipment used therein;
2. Delivery room and equipment used therein;
3. Other treatment rooms and equipment used therein;
4. Prescribed drugs;
5. Anesthesia, anesthesia supplies and services provided by an employee of the Facility;
6. Medical and surgical dressings, supplies, casts and splints;
7. Blood, blood transfusions and other blood-related services; and
8. Diagnostic Services.

### **Cardiac Rehabilitation Therapy – Outpatient**

The Plan will cover Cardiac Rehabilitation Therapy which is deemed Medically Necessary in connection with the rehabilitation of the Covered Person following a myocardial infarction, coronary occlusion or coronary bypass surgery when such rehabilitation services are rendered under the supervision of a Physician in a Facility. Such rehabilitation services must be rendered within 12 weeks after other treatment for the medical condition ends.

### **Chemotherapy – Outpatient**

The Plan will cover chemotherapy treatment rendered by a Physician or Other Medical Professional Provider when such treatment is rendered.

### **Chiropractic Services – Outpatient**

The Plan will cover Chiropractic Treatment when rendered by a Physician or a Chiropractor on an Outpatient basis. As used herein, Chiropractic Treatment means treatment of the spine by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease or injury. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Other Medical Professional Provider are required.

### **Clinical Cancer Trials - Phases II, III, and IV**

The Plan will cover routine patient care costs incurred as the result of phase II, III, or IV of a clinical trial for the purposes of the prevention, early detection, or treatment of cancer. Coverage shall include routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

In the case of treatment under a clinical trial:

1. The treating Facility and Provider personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients;
2. There must be equal to or superior, non-investigational treatment alternatives; and
3. The available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

**Phase II** - Coverage is provided for routine patient care costs incurred during phase II of a clinical trial if:

1. Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at an academic or National Cancer Institute Center; and
2. The Covered Person is actually enrolled in the clinical trial and is not only following the protocol of phase II of a clinical trial.

**Phase III and Phase IV** - Coverage is provided for routine patient care costs incurred during phase III or IV of clinical trials that are approved or funded by one of the following entities:

1. One of the National Institutes of Health (NIH);
2. An NIH cooperative group or center;
3. The U.S. Food and Drug Administration (FDA) in the form of an investigational new drug application;
4. The federal Departments of Veterans' Affairs or Defense;

5. An institutional review board in the State of Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
6. A qualified research entity that meets the criteria for NIH Center support grant eligibility.

“Routine patient care cost”, as used herein, means the cost of a reasonable and medically necessary service needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except: (a) the investigational item or service (e.g., the drug or device) itself; (b) items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and (c) items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

### **Dental Services**

The Plan will cover the following dental services when rendered and billed by a Physician or Other Medical Professional Provider:

1. Emergency repair due to Injury to sound natural teeth provided such treatment is performed within 12 months of the onset of the Injury;
2. Correction of congenital abnormalities of the jaw;
3. Reduction of fractures of facial bones;
4. Excision of mandibular joints;
5. Excision of lesions; and
6. Removal of impacted wisdom teeth.

Coverage will not be provided for dental oral surgical procedures involving orthodontic care of the teeth, periodontal diseases and preparing the mouth for the fitting of or continued use of dentures.

### **Diagnostic Services - Outpatient**

The Plan will cover Outpatient Diagnostic Services rendered in an Outpatient Facility or Physician Office setting when the Covered Person has specific symptoms and such tests and procedures are needed to detect and diagnose an Illness or Injury. Outpatient Diagnostic Services include, but are not limited to, Outpatient Diagnostic Services for pre-admission testing and allergy testing. Specific services covered under this benefit include:

- MRA of the Head and/or Neck
- MRI of the Brain
- MRI of Spine – Cervical, Thoracic, Lumbar, Sacral
- PET Scans

**Note:** The Covered Person is required to obtain pre-certification for the following diagnostic procedures: MRA of the head and/or neck; MRI of the brain and/or spine; and PET scans. Refer to the section entitled “Pre-Certification Provisions and Case Management” for details.

### **Drug Addiction Services**

Refer to the Substance Abuse Services benefit.

## **Durable Medical Equipment**

The Plan will cover the rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician. Rental costs must not be more than purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use.

**Note:** The Covered Person is required to obtain pre-certification for the following:

- Tens Units
- Neuromuscular Stimulators
- Functional Electrical Stimulators
- Bikes
- Custom Wheelchairs
- Power Wheelchairs
- Cooling Devices (e.e. Polar Care)
- Cochlear Implant
- Bone Stimulator
- Wound Vacs
- Electric Scooters
- Cardio/External Defibrillator
- Myoelectric Prosthetics
- CPAP/BIPAP
- Limb Prosthetics

Refer to the section entitled “Pre-Certification Provisions and Case Management” for details.

## **Emergency Care in Emergency Department**

The Plan will cover treatment of an Illness or Injury when such services are rendered in the Emergency Department of a Hospital. Covered Services include those Medically Necessary services and supplies provided by the Hospital following the Covered Person’s admission to the Emergency Department for an Illness or Injury and include the services provided by the Physician and Other Medical Professional Providers who are Hospital employees and who are regular staff members of the Emergency Department of the Hospital.

## **Home Health Care Services**

Home Health Care Services may be provided to the Covered Person on a part-time basis in the Covered Person’s home as a Medically Necessary alternative to Inpatient care. A Home Health Care Provider must provide the services according to a Physician-prescribed course of treatment that has been previously approved by the Plan. Four hours of home health care services shall equal one visit from the Home Health Care Provider. Covered Services include the following:

1. Medical appliances and equipment;
2. Medical supplies, drugs, and medications which the Covered Person cannot self-administer;
3. Laboratory services;
4. Skilled nursing services; and
5. Home health aide service.

**Note:** The Covered Person is required to obtain pre-certification for Home Health Care Services. Refer to the section entitled “Pre-Certification Provisions and Case Management” for details.

## Hospice Services

Hospice Services are the following services that are provided to a terminally ill patient with a life expectancy of six (6) months or less. Hospice Services must be provided by a Hospice Provider according to a Physician-prescribed plan of care that has been previously approved by the Plan.

Covered Services include the following:

1. Nursing Care;
2. Medical Social Services;
3. Physical, Speech and Occupational Therapy;
4. Inhalation Therapy;
5. Home Health Aide Services;
6. Dietary Counseling;
7. Medical/Surgical Supplies;
8. Medical Equipment;
9. Lab Services;
10. Bereavement Counseling - Must be furnished within the first six months following the patient's death and are provided for the patient's immediate family members (Covered Spouse and Covered Dependent Children); and
11. 24 Hour Continuous Nursing Care.

Hospice Services are most often provided in the home and must be agreed to by the Covered Person.

## Hospital Services During an Inpatient Confinement

The Plan will cover certain Hospital Services when the Covered Person is hospitalized as an Inpatient in a Hospital. The following room and board expenses and ancillary services are considered covered Inpatient Hospital Services:

1. **Room and Board.** Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services. Coverage includes a bed in a special care unit approved by the Plan. Benefits are limited to the semi-private room rate. However, the Plan will cover a private room at the semi-private room rate if the Hospital does not provide semi-private rooms or if no semi-private rooms are available.
2. **Ancillary Services.** Ancillary Services received during a Hospital Confinement include, but are not limited to:
  - a. Operating room and equipment used therein;
  - b. Delivery room and equipment used therein;
  - c. Other treatment rooms and equipment used therein;
  - d. Prescribed drugs;
  - e. Anesthesia, anesthesia supplies and services provided by an employee of the Facility;
  - e. Medical and surgical dressings, supplies, casts and splints;
  - f. Blood, blood transfusions and other blood-related services;
  - g. Diagnostic Services;
  - h. Radiation Therapy;
  - i. Intravenous chemotherapy;
  - j. Kidney dialysis;
  - k. Inhalation Therapy;
  - l. Physical Therapy;
  - m. Occupational Therapy; and
  - n. Speech Therapy.

Note: Pre-certification must be obtained for Hospital Services rendered during an Inpatient Confinement. Refer to the section entitled “Pre-Certification Provisions and Case Management” for details.

### **Human Papillomavirus (HPV) Vaccinations**

The Plan will cover Human Papillomavirus (HPV) vaccinations for the prevention of cervical cancer and other diseases caused by Human Papillomavirus. Coverage is provided for covered females who are under the age of 24. Coverage will be limited to three separate doses of the vaccination that are given at the following intervals prior to reaching age 24: baseline (the initial injection), two months and six months.

### **Infertility Services**

The Plan will cover expenses for care, supplies and services including infertility drugs for the diagnosis and treatment of infertility. Coverage for infertility services is limited to a Maximum Benefit of \$15,000 per family per lifetime. The Plan will **not** cover expenses for sterilization reversals.

### **Inhalation (Respiration) Therapy – Outpatient**

The Plan will cover inhalation therapy when rendered by a Physician or Other Medical Professional Provider on an Outpatient basis. As used herein, inhalation therapy means a type of therapy that involves the introduction of dry or moist gases into the lungs.

### **Kidney Dialysis**

The Plan will cover Outpatient Dialysis treatment when such services are rendered and billed by a Preferred or Non-Preferred Provider. All Covered Persons receiving Outpatient Dialysis treatment will be subject to the Plan’s case management provisions, negotiations and other Plan services which the Plan Sponsor may elect to apply in the exercise of its discretion.

Payment for Outpatient Dialysis Treatment will be based on the Outpatient Dialysis Usual and Reasonable Charge, as defined herein. The Plan shall pay no more than the Outpatient Dialysis Usual and Reasonable Charge in connection with Outpatient Dialysis claims, after deduction of all amounts subject to Deductible, Coinsurance, or applicable Copayments.

### **Maternity Services**

**Inpatient Services.** Coverage will be provided for the services rendered by a Hospital or Professional Provider in connection with the Maternity Services for all Covered persons under the plan. The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Dependent Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Provider (e.g. the Covered Person’s Physician, Certified Nurse Midwife, or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, the Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not require that a Physician or other Provider obtain authorization for prescribing a length of stay unless the length of stay will exceed 48 hours for a vaginal delivery or 96 hours for a cesarean section.

**Pre-Natal and Post-Natal Office Visits.** Coverage will be provided for office visits in connection with pre-natal and post-natal care and treatment of the mother. Pre-natal and post-natal office visits will be treated as a Maternity Service and will be covered in the same manner as all other Maternity Services. However, the initial pre-natal office visit may be covered under the Physician Office Visit benefit (refer to the Schedule of Benefits) if the Physician does not bill the initial office visit as part of the overall obstetrical bill.

**Routine Nursery Care of Well Newborn.** This benefit includes the routine nursery care of the newborn infant and the first Inpatient visit to examine the infant. A Physician other than the Physician who performed the obstetrical delivery must perform the examination. When the mother is discharged from the Hospital, continued Coverage for the infant will only be provided if the infant has been enrolled for Coverage under the Plan pursuant to the enrollment requirements described in this Plan Document.

**Rho(D) Injections.** The Plan will cover Rho(D) injections administered at 28 weeks of Pregnancy when such an injection is deemed to be Medically Necessary.

### **Medical and Surgical Supplies**

The Plan will cover medical and surgical supplies that serve a specific medical purpose and are purchased by the Covered Person for use in the home. Covered medical and surgical supplies include, but are not limited to, the following:

1. Syringes and needles;
2. Oxygen;
3. Surgical dressings;
4. Casts and splints;
5. Braces;
6. Catheters;
7. Colostomy and ileostomy bags and supplies required for their use;
8. Soft lenses and sclera shells intended for use in the treatment of an Illness or Injury of the eye; and
9. Allergy serum and intravenous solutions unless such serum and IV solutions are obtained from a Pharmacy (refer to Prescription Drug Coverage).

Covered Services do not include items usually stocked in the home for general use like adhesive bandages, thermometers and petroleum jelly.

**Nutritional Counseling:** Nutritional counseling is a type of assessment made which analyzes various health needs in regard to diet and exercise. A nutritional counselor helps people to set achievable health goals and teaches various ways of maintaining these goals throughout their lifetime. The nutritional counselor provides information based on a person's current status, helping to improve overall health

### **Occupational Therapy Services - Outpatient**

The Plan will cover Outpatient Occupational Therapy when rendered and billed by a Physician or Other Medical Professional Provider. As used herein, Occupational Therapy means treatment rendered on an Inpatient or Outpatient basis as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts).

**Note:** The Covered Person is required to obtain pre-certification for Occupational Therapy Services. Refer to the section entitled "Pre-Certification Provisions and Case Management" for details.

### **Organ Transplants**

**Transplant Network:** In addition to the Providers available through the PPO Network(s) provided by Missouri Department of Conservation, the Plan, has made available a specialized network of Providers able to provide services and treatment in connection with covered Transplants Services. This transplant network consists of Facility Providers that are part of a "Center of Excellence" and specialize in providing transplant related services.

Although the Providers participating in the transplant network may not be part of the PPO Network(s) selected by Missouri Department of Conservation, services rendered by a Center of Excellence provider will be paid at the In-Network benefit level. This higher benefit level, which is set forth in the Schedule of

Benefits, applies to all Eligible Expenses received in connection with the covered transplant procedure when a Center of Excellence performs the actual transplant surgery. To determine which Hospitals are considered a Center of Excellence, the Covered Person or the Covered Person's Physician should contact the Medical Management Company as soon as the Covered Person becomes a candidate for a transplant procedure. The Medical Management Company will be able to direct the Covered Person or the Covered Person's Physician to a list of Hospitals that qualify as a Center of Excellence.

### **Orthotics and Initial Orthotic Devices**

The Plan will cover consider Coverage of orthotic devices when a letter of Medical Necessity has been provided by the Covered Person's Physician. Under the Plan, orthotic devices are rigid or semi-rigid supportive devices which limit or stops motion of a weak or diseased body part. In addition, orthotic devices include orthopedic shoes or corrective shoes provided such shoes are an integral part of a leg brace, and other supportive devices.

### **Patient Education Programs**

The Plan will cover patient education programs for ostomy care and diabetic education.

### **Physical Therapy Services - Outpatient**

The Plan will cover Physical Therapy when rendered by a Physician or Physical Therapist. As used herein, Physical Therapy means treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Other Medical Professional Provider are required.

Such treatment does not include treatment of the spine which is covered under the chiropractic benefit.

**Note:** The Covered Person is required to obtain pre-certification for Physical Therapy Services. Refer to the section entitled "Pre-Certification Provisions and Case Management" for details.

### **Physician Office Visits for Non-Routine Care**

The Plan will cover charges incurred during a visit to the Covered Person's Physician for non-routine care in connection with a specific Injury or Illness. Covered Services includes screening examinations, evaluation procedures, medical care, treatment or services directly related to assist in the diagnosis or treatment of a specific Injury or Illness which is known or reasonably suspected.

### **Physician Office Visits for Well Care**

Refer to Routine/Well Care benefit.

## **Physician Visits During Inpatient Hospital Confinement**

The Plan will cover Physician visits and certain other consultation services for a Covered Person who is hospitalized as an Inpatient in a Hospital. Services under this benefit include:

1. **Physician In-Hospital Visits.** The Plan will cover one Physician visit per day from the Covered Person's treating Physician during a Covered Person's Hospital Confinement.
2. **Intensive Care.** The Plan will cover the constant care and treatment while the Covered Person is confined in an intensive care unit.
3. **Care by Multiple Physicians.** When the Covered Person's condition requires the skills of separate Physicians, the Plan will cover the medical care and treatment by two or more Physicians received during the same Hospital Confinement.
4. **Other Physician Consultations.** When the Covered Person's Physician requests another Physician's consultation, the Plan will provide Coverage for such consultation but will limit Coverage to one such consultation per Hospital admission. Staff consultations required by Hospital rules are excluded from Coverage.

## **Podiatry Services**

The Plan will cover podiatry services rendered by a Podiatrist or a Physician when deemed Medically Necessary due to illness and for diabetics. Covered services include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

## **Private Duty Nursing Services**

Coverage is provided for services of a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) when ordered by a Physician. Nursing services do not include care that is primarily non-medical or custodial in nature such as bathing, exercising, and feeding.

**Inpatient Services** - Services that are determined to be of such nature or degree of complexity that the Provider's regular nursing staff cannot give them.

**Home Services** - Services that are determined to require an R.N. or L.P.N.'s continual skills. Benefits are not provided for a nurse who usually lives in the Covered Person's home, or is a member of the Covered Person's immediate family.

## **Prosthetic Appliances**

The Plan will cover the purchase, fitting, needed adjustment, repairs, and replacements of prosthetic appliances and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body organ.

Covered prosthetic appliances include prostheses in connection with breast reconstruction following a covered mastectomy procedure.

## **Psychiatric Services**

The Plan will cover Psychiatric Services for the care and treatment of a psychiatric condition. Psychiatric Services will be covered on Inpatient and Outpatient basis and during a Partial Day Treatment Program. A psychiatric condition will be treated the same as any other Illness for purposes of determining available Covered Services. In addition, the following additional services are covered:

1. Individual psychotherapy;
2. Group psychotherapy;
3. Psychological testing;
4. Family counseling - Counseling with family members to assist in the Covered Person's diagnosis and treatment, except marriage counseling; and
5. Convulsive therapy - Convulsive therapy treatment is limited to Inpatient care. It includes electroshock treatment or convulsive drug therapy.

Psychiatric Services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, or Community Mental Health Facility.

## **Radiation Therapy – Outpatient**

The Plan will cover radiation therapy when rendered by a Physician or Other Medical Professional Provider on an Outpatient basis.

## **Reconstructive Surgery**

The Plan will cover reconstructive surgery to restore bodily functions or correct deformity. Such surgical procedure will be treated the same as any other surgical procedure. Coverage is limited to problems caused by disease, Injury, birth or growth defects, or previous treatments. In addition, Coverage will be provided for the following services in connection with a mastectomy:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

## **Routine/Well Care for Adult**

Coverage will include charges for all Covered Persons for routine periodic examinations, screening examinations, medical assessments, evaluation procedures, preventative medical care, treatment or services not directly related to a specific Injury, Illness or pregnancy-related condition which is known or reasonably suspected. Specific services covered under this benefit include:

1. Routine physical examination, limited to 1 per calendar year;
2. Routine gynecological exam, limited to 1 per calendar year;
3. Routine pap smear screening, limited to 1 per calendar year;
4. Routine PSA screening, limited to 1 per calendar year;
5. Routine digital rectal examination, limited to 1 per calendar year;
6. Routine or diagnostic colonoscopy, limited to 1 every 10 years after the age of 50;
7. Bone density scan, limited to 1 per calendar year;

8. Routine mammogram screening, limited to 1 per calendar year;
9. Routine immunizations including:
  - a. Hepatitis shots;
  - b. Flu shots & flu mist
  - c. Pneumovax;
  - d. Tetanus shots; and
10. All diagnostic laboratory examinations in connection with the routine Physician Office Visit.

### **Routine/Well Care for Dependent Child**

Coverage will include charges for a Dependent Child from birth to age 17 for routine periodic examinations, screening examinations, medical assessments, evaluation procedures, preventative medical care, treatment or services not directly related to a specific Injury, Illness or pregnancy-related condition which is known or reasonably suspected. Specific services covered under this benefit include:

1. Routine physical examinations;
2. Routine immunizations; and
3. All diagnostic laboratory examinations in connection with the routine Physician office visit, including those screenings mandated by the State of Missouri for newborn screening requirements for potentially treatable or manageable disorders (e.g., Cystic Fibrosis, amino acid disorders, etc.), lead poisoning screenings and newborn hearing screenings.

### **Second and Third Surgical Opinions**

When the Covered Person's Physician recommends that a surgical procedure be performed, the Plan will cover a consultation with a Physician in order to obtain a second opinion in connection with the recommended surgery. The Physician providing the second opinion must be a Physician who is qualified to perform the surgery. Charges incurred for a second surgical opinion must be billed as a second surgical opinion. Otherwise, Eligible Expenses will be paid as any other Illness. If the second opinion differs from the first opinion obtained, the Plan will cover a consultation with a third Physician.

### **Skilled Nursing Facility Services**

The Plan will cover the following expenses in connection with a Skilled Nursing Facility Confinement:

1. **Room and Board.** Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services. Coverage includes a bed in a special care unit approved by the Plan. Benefits are limited to the prior hospital's semi-private room rate.
2. **Ancillary Services.** Ancillary Services received during a Hospital Confinement include, but are not limited to:
  - a. Treatment rooms and equipment used therein;
  - b. Prescribed drugs;
  - c. Medical and surgical dressings, supplies, casts and splints;
  - d. Diagnostic services; and
  - e. Certain therapy services such as Inhalation Therapy, Physical Therapy, Occupational Therapy and Speech Therapy.

Services must be Medically Necessary as a continuation of treatment for the condition for which the Covered Person was hospitalized.

## **Speech Therapy – Outpatient**

The Plan will cover Speech Therapy when rendered and billed by a Physician or licensed Speech Therapist. As used herein, Speech Therapy means active treatment for the correction of a speech impairment resulting from a disease, surgery, injury, congenital or developmental anomalies, or for previous therapeutic processes. Treatment must be Medically Necessary, ordered by a Physician, and either post-operative or for the convalescent stage of an active illness or disease.

### **Notes:**

1. The Covered Person is required to obtain pre-certification for Speech Therapy. Refer to the section entitled “Pre-Certification Provisions and Case Management” for details.
2. **The Plan requires that a Covered Person utilize a school speech therapy program, if available, but will not cover such services under this Plan.**

## **Sterilization Services**

The Plan will cover surgical services in connection with a voluntary sterilization procedure when such services are rendered and billed by a Physician. In addition, any services rendered by a Hospital, Ambulatory Surgical Facility or Other Medical Facility Provider in which such procedure is performed and that are rendered and billed by such Facility Provider will also be covered by the Plan.

## **Substance Abuse Services**

The Plan will cover Substance Abuse Services for the care and treatment of alcoholism and drug addiction. Substance Abuse Services will be covered on an Inpatient and Outpatient basis. In addition, Partial Day Treatment Programs are also covered. Covered Services include those services that would be covered for any other Illness, as set forth in this Plan Document, and also include the following services:

1. Individual psychotherapy
2. Group psychotherapy
3. Psychological testing
4. Family counseling - Counseling with family members to assist in the Covered Person’s diagnosis and treatment, except marriage counseling.

Substance Abuse Services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, Alcoholism Treatment Facility or Community Mental Health Facility.

## **Surgical Services**

Surgery performed by a Physician is covered on an Inpatient or Outpatient basis. Inpatient basis includes surgery performed by a Physician while the Covered Person is an Inpatient in a Hospital. Outpatient basis includes Surgical Services performed in a Facility or a Physician’s Office. Surgical services also include:

1. **Surgical Assistance.** Services of a Physician who helps the Covered Person’s surgeon in performing covered major surgery when a house staff member, intern or resident cannot be present. In this instance, the Provider’s Allowable Charge for services of a Physician who assists the surgeon in performing a covered surgery will be determined as 20% of the surgeon’s charge for the surgery; and

2. **Multiple Surgical Procedures.** When more than one surgical procedure is performed through the same body opening during one operation, the Covered Person is covered only for the most complex procedure. If more than one body system is involved or the procedures are needed for the handling of multiple traumas, then the Plan will base payment on 100% of the Provider's Reasonable Charge for the most complex procedure and 50% of the Provider's Reasonable Charge for each additional procedure performed.

When more than one surgical procedure is performed through more than one body opening during one operation, then the Plan will base payment on 100% of the Provider's Reasonable Charge for the most complex procedure and 50% of the Provider's Reasonable Charge for each additional procedure performed.

**Note:** The Covered Person is required to obtain pre-certification for the following surgical procedures:

1. Cholecystectomy (Laparoscopic);
2. Hysterectomy when performed on a Covered Person under the age of 30;
3. Nasal Septoplasty/Rhinoplasty.

Refer to the section entitled "Pre-Certification Provisions and Case Management" for details.

### **Therapy Services – Outpatient**

The following therapy services will be covered when rendered by a Physician or Other Medical Professional:

1. Chemotherapy;
2. Home Infusion Therapy;
3. Occupational Therapy;
4. Speech Therapy;
5. Physical Therapy;
6. Radiation Therapy;
7. Cardiac Rehabilitation Therapy; and
8. Chiropractic Treatment.

In addition, the Plan will cover Cardiac Rehabilitation Programs in connection with the rehabilitation of the Covered Person following a myocardial infarction or coronary occlusion or coronary bypass surgery when such rehabilitation services are rendered under the supervision of a Physician in a Facility.

### **TMJ Treatment - Outpatient**

The Plan will cover surgical procedures for Covered Persons with Temporomandibular Joint (TMJ) Dysfunction. However, the Plan will **not** cover any type of orthodontic device, crowns, or inlays for the treatment of TMJ.

## **Transplant Services**

The Plan will cover services in connection with a transplant procedure to replace an organ or tissue when such services are deemed Medically Necessary and are rendered and billed by a Physician and/or Hospital. The Plan will cover charges for obtaining donor organs and tissues when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan shall be reduced by those which were payable under the donor's plan. Donor charges include those for evaluating the organ or tissue and removing the organ or tissue. In addition, the Plan will cover expenses for the acquisition (including the evaluation of the organ or tissue and the removal of such organ or tissue) and transportation of the organ or tissue from within the United States or Canada to the place where the transplant procedure is scheduled to occur.

The Plan will cover travel and lodging expenses in connection with a covered transplant procedure. When the recipient is a Covered Person under this Plan, the Plan will cover travel and lodging expenses for the recipient (the Covered Person receiving the transplant procedure) and, if the recipient is a minor, the travel and lodging expenses of two (2) adult companions when such companions are Covered Persons under this Plan (e.g., the Covered Person's parents). If the recipient is an adult, the Plan will cover the travel and lodging expenses of one adult companion when such companion is a Covered Person under this Plan. When the donor is a Covered Person under this Plan, the Plan will cover travel and lodging expenses limited to the expenses of the donor.

## **Urgent Care Services in Urgent Care Facility**

The Plan will cover services rendered by an Urgent Care Facility in connection with the treatment and diagnosis of an Illness or Injury, and include the services provided by the Physician and Other Medical Professional Providers who are Urgent Care Facility employees. Under this benefit, Coverage will be provided for screening examinations, evaluation procedures, medical and surgical care, treatment or services directly related to a specific Injury or Illness which is known or reasonably suspected.

## **Wigs**

The Plan will cover wigs as a prosthesis for Dependent Children under the age of 19 for hair loss due to the diagnosis of Alopecia Areata and Alopecia Totalis.

## EXCLUSIONS OR LIMITATIONS TO THE MEDICAL BENEFITS

1. **Admissions Primarily for Diagnostic Studies.** The Plan will not cover room, board and general nursing care for Hospital admissions mainly for diagnostic studies;
2. **Admissions Primarily for Physical Therapy.** The Plan will not cover room, board and general nursing care for Hospital admissions mainly for Physical Therapy;
3. **Alternative Treatments.** The Plan will not cover treatments that are deemed to be “alternative treatments” including, but not limited to, the following: naturopathy, psychosurgery, massage therapy, megavitamin therapy, nutritionally based alcoholism therapy, holistic or homeopathic care including drugs, ecological or environmental medicine, hypnotherapy or hypnotic anesthesia, hippotherapy, and sleep therapy. The Plan will not cover acupuncture or acupressure unless it is deemed Medically Necessary;
4. **Braces and Artificial Limbs.** The Plan will not cover charges for replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is a sufficient change in the Covered Person’s physical condition to make the original device no longer functional;
5. **Certain Counseling Services.** The Plan will not cover marriage counseling, family counseling, pastoral counseling, financial counseling, legal counseling and custodial care counseling, except as specifically set forth in this Plan Document;
6. **Certain Examinations and Services.** The Plan will not cover examinations or medical services the Covered Person receives specifically for the purpose of employment, recreation, insurance, school attendance or licensure;
7. **Controlled Substance.** The Plan will not cover charges for the care or treatment of an Illness or Injury resulting from the voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not administered by a Physician;
8. **Cosmetic Services.** The Plan will not cover expenses in connection with or treatment only to improve appearance, except as specifically set forth herein. This exclusion does not include procedures to restore body function or correct deformity from disease, trauma, birth or growth defects or prior therapeutic processes;
9. **Criminal Act.** The Plan will not cover charges for services and supplies incurred as a result of an Illness or Injury, caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance;
10. **Custodial Services.** The Plan will not cover expenses or services for custodial care or for services not needed to diagnose or treat an Injury or Illness and will furthermore not cover Hospital Confinements for custodial care or for custodial treatment for a psychiatric or substance abuse disorder;
11. **Drugs.** The Plan will not cover expenses for over-the-counter or prescription drugs purchased and administered on an Outpatient basis, except as specified herein. Prescription drugs administered while an Inpatient in a Hospital will be covered under the Plan;
12. **Dental Services.** The Plan will not cover expenses for dentistry or dental processes, except as specified;
13. **Dental or Medical Department/Clinic.** The Plan will not cover expenses incurred or services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group;

14. **Educational or Training.** The Plan will not cover expenses for services or supplies primarily for educational, vocational or training purposes;
15. **Exercise Program.** The Plan will not cover expenses for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by the Plan;
16. **Experimental or Investigative Services.** The Plan will not cover expenses for any services that are Experimental or Investigative with the exception of services rendered as part of a clinical cancer trial as described in the Covered Services section of this Plan Document;
17. **Eye Glasses.** The Plan will not cover expenses for eye glasses, sunglasses, safety glasses, safety goggles, subnormal vision aids or contact lenses (except for aphakic patients and soft lenses or sclera shells which are intended for use as corneal bandages);
18. **Family Member.** The Plan will not cover expenses or services received from a member of the Covered Persons' household or from an Immediate Family Member. For the purposes of this exclusion, Immediate Family Member means the Covered Employee, his or her spouse, Dependent Child, brother, sister, parent, or brother-in-law, sister-in-law or parent-in-law;
19. **Governmental Agency or Program.** The Plan will not cover expenses to the extent governmental units or governmental programs provide benefits;
20. **Hearing Aids.** The Plan will not cover expenses for hearing aids or examinations for prescribing or fitting them;
21. **Impotence Treatment.** The Plan will not cover expenses for care, treatment, services, supplies or medication in connection with treatment for impotence;
22. **Inappropriate Charges.** The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed inappropriate or unnecessary by the AMA or is otherwise deemed inappropriate or unnecessary in accordance with accepted medical standards and practice;
23. **Legal Obligation to Pay.** The Plan will not cover expenses for which the Covered Person has no legal obligation to pay in the absence of this or like coverage;
24. **Lifestyle Improvement Services.** The Plan will not cover lifestyle improvement services or charges, including, but not limited to, physical fitness programs and equipment, spas, air conditioners, humidifiers, personal hygiene and convenience items, mineral baths, massage and dietary supplements;
25. **Marital Counseling.** The Plan will not cover services in connection with marital counseling;
26. **Medicare.** The Plan will not cover expenses for which benefits are payable under Medicare Part A, Part B or Part D or would have been payable if a Covered Person had applied for Part A, Part B and/or Part D, except as specified in this Plan Document;
27. **Non-Covered Services.** The Plan will not cover services that are not specified in this Plan Document as Covered Services.
28. **Non-Medically Necessary Services.** The Plan will not cover services or supplies that are not considered to be Medically Necessary as defined herein;

29. **Patient Education Programs.** The Plan will not cover expenses for patient education programs except those specifically stated herein;
30. **Podiatry Services.** The Plan will not cover expenses for foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular or bone surgery), calluses, toenails, and the like;
31. **Pre-Existing Conditions.** The Plan will not cover expenses for the treatment of a Pre-Existing Condition, during the Pre-Existing Condition Waiting Period for Covered Persons aged 19 or older
32. **Prior to Effective Date or After Termination Date.** The Plan will not cover expenses incurred prior to the Covered Person's Effective Date or after the termination date except as specified in this Plan Document;
33. **Private Room Charges.** The Plan will not cover charges for a private room while the Covered Person is an Inpatient in a Hospital or Skilled Nursing Facility unless such private room is deemed Medically Necessary or except as otherwise stated herein;
34. **Preventative and Routine Services.** The Plan will not cover preventative services, routine office visits or routine periodical physical examinations for a Covered Person, except as specified in this Plan Document;
35. **Sleep Disorders.** The Plan will not cover charges for the treatment of sleep disorders;
36. **Smoking Cessation Programs.** The Plan will not cover expenses for care and treatment for smoking cessation programs, including smoking deterrent patches;
37. **Speech Therapy.** The Plan will not cover school speech therapy programs even though the Plan requires a Covered Person to utilize such program if one is available;
38. **Sterilization Reversal.** The Plan will not cover expenses for the reversal of a sterilization procedure;
39. **Telephone Consultations, Missed Appointments, Claim Form Completion.** The Plan will not cover expenses for telephone consultations, missed appointments, or completion of claim forms;
40. **TMJ Devices and Services.** The Plan will not cover services or devices in connection with TMJ except as set forth herein;
41. **Transplant Services.** The Plan will not cover transplant procedures or services other than those specified herein;
42. **Transsexual Surgery.** The Plan will not cover expenses for transsexual surgery or any treatment leading to or in connection with transsexual surgery. This exclusion includes gender dysphoria or sexual reassignment or change, medications, implants, hormone therapy, surgery, medical or psychiatric treatment in connection with such surgery or treatment;
43. **Vision Services.** The Plan will not cover expenses for eye care, including radial keratotomy or other eye surgery to correct refractive disorders. The Plan will not cover expenses for eye examinations, except as specified herein, including lenses for the eyes and examinations for the fitting of lenses. In addition, eye examinations for any occupational condition, ailment or Injury arising out of or in the course of employment will not be covered. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages;

44. **Weight Control or Related Treatments.** The Plan will not cover dietary products, supplies or treatment for controlling or reducing weight, obesity treatments, and exercise programs; and
45. **Wigs.** The Plan will not cover expenses for care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except as specifically stated herein on page 37.

## **PRESCRIPTION DRUG BENEFITS**

This section describes the Prescription Drug Benefits. The Plan will provide Coverage for the Prescription Drug Benefits when services:

1. Are authorized by a Physician;
2. Are rendered and billed by a Provider;
3. Qualify as a Covered Service; and
4. Are Medically Necessary, except as specified.

## **PHARMACY COVERAGE**

Covered Drugs are drugs that require a prescription under federal law, are approved for general use by the Food and Drug Administration and are dispensed for the Covered Person's Outpatient use by a licensed Pharmacy on or after his/her Effective Date. Each covered prescription is limited to a 30-day supply.

Under the Pharmacy Coverage, there are different Copayment amounts. The Copayment amounts are listed in the Prescription Drug Coverage Schedule of Benefits. The Copayment applies each time the Covered Person purchases a Prescription Drug.

Formulary lists which indicate the Formulary Brand Name Drugs are established by the Drug Program Vendor and are subject to change. To request a copy of the formulary list, the Covered Person should contact the Prescription Drug Vendor at the telephone number indicated on the Covered Person's identification card.

Prescriptions obtained from a Non-Participating Pharmacy will **not** be covered unless Prior Authorization is obtained. Refer to the Definitions section for a definition of Prior Authorization.

## **MAIL ORDER PRESCRIPTION DRUG COVERAGE**

The Plan will also cover maintenance drugs which require a prescription under federal law, are approved for general use by the Food and Drug Administration and are dispensed for the Covered Person's Outpatient use by the Mail Order Drug Company on or after the Effective Date. Each covered prescription is limited to a 90-day supply.

When purchasing prescription drugs through the Mail Order Drug Company, there are different Copayment amounts. The Copayment amounts are listed in the Prescription Drug Coverage Schedule of Benefits. The Copayment applies each time the Covered Person purchases a Prescription Drug.

Formulary lists which indicate the Formulary Brand Name Drugs are established by the Drug Program Vendor and are subject to change. To request a copy of the formulary list, the Covered Person should contact the Prescription Drug Vendor at the telephone number indicated on the Covered Person's identification card.

## **OVER THE COUNTER (OTC) DRUG COVERAGE**

Effective January 1, 2008, the Plan will cover certain over the counter (OTC) drugs as an alternative to specific drugs for specific conditions. Refer to the Prescription Drug Coverage Schedule of Benefits for details.

## COVERED PRESCRIPTION DRUGS

The following is a list of prescription drugs covered by the Plan:

1. All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan;
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity; and
3. Insulin and other diabetic supplies, limited to lancets, test strips and glucose meters, when prescribed by a Physician. Glucose meters are covered under the Plan's Medical Benefits. Refer to the section entitled Durable Medical Equipment. Diabetic supplies not listed herein as a Covered Prescription Drug will require Prior Authorization before the Plan shall cover such supplies. Other injectables are not covered except as specifically stated herein.

**Note: Specialty Drugs** - Specialty drugs will be considered Eligible Expenses under the Plan when such prescriptions are obtained through the Prescription Drug Vendor's specialty drug program. Specialty drugs may be subject to Prior Authorization requirements. Specialty drugs include, but are not limited to, injectable drugs for the treatment of chronic diseases such as growth hormone disorders, hemophilia, hepatitis and respiratory syncytial virus (RSV). There are special requirements for the handling and administration of such specialty drugs. The Covered Person should contact the Specialty Drug Vendor Curascript at 888-773-7376 for more information and to obtain the necessary Prior Authorization before purchasing such specialty drugs. Each covered prescription is limited to a 30-day supply.

## EXCLUSIONS OR LIMITATIONS TO THE PRESCRIPTION DRUG BENEFITS

No Prescription Drug benefits are provided for the following:

1. **Administration Charges.** The Plan will not cover charges for the administration or injection of any drug;
2. **Appetite Suppressants.** The Plan will not cover appetite suppressants, unless specified otherwise;
3. **Contraceptives.** The Plan will not cover charges for injectable contraceptives, Norplant insertion or other contraceptive devices, unless specified otherwise.
4. **Controlled Substance.** The Plan will not cover charges for the care or treatment of an Illness or Injury resulting from the voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not administered by a Physician;
5. **Cosmetic.** The Plan will not cover charges for any prescription used for treatment only to improve appearance;
6. **Criminal Act.** The Plan will not cover charges for services and supplies incurred as a result of an Illness or Injury, caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance;
7. **Diabetic Supplies.** The Plan will not cover charges for diabetic supplies other than those specifically stated herein, unless Prior Authorization is obtained prior to purchasing such supplies;

8. **Drugs without Prescriptions.** The Plan will not cover drugs that do not require a prescription by federal law;
9. **Excess Prescription Refills.** The Plan will not cover any prescription refilled in excess of the number of times specified by the Physician;
10. **Experimental or Investigative.** The Plan will not cover any drugs labeled "Caution - limited by federal law to investigational use," or drugs that are Experimental or Investigational, even though a charge is made to the individual;
11. **Family Member.** The Plan will not cover expenses or services received from a member of the Covered Persons' household or from an Immediate Family Member. For the purposes of this exclusion, Immediate Family Member means the Covered Employee, his or her spouse, Dependent Child, brother, sister, parent, or brother-in-law, sister-in-law or parent-in-law;
12. **Fertility Medication.** The Plan will not cover fertility medication, unless specified otherwise;
13. **Governmental Agency or Program.** The Plan will not cover services for which benefits are payable by any governmental agency or program;
14. **Growth Hormones.** The Plan will not cover growth hormones, unless specified otherwise;
15. **Immunization Agents and Blood Expenses.** The Plan will not cover immunization agents, biological sera, blood or blood plasma;
16. **Impotence Medication.** The Plan will not cover any impotence medication, except for erectile dysfunction medication;
17. **Inappropriate Charges.** The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed inappropriate or unnecessary by the AMA or is otherwise deemed inappropriate or unnecessary in accordance with accepted medical standards and practice;
18. **Injectables.** The Plan will not cover charges for hypodermic syringes and/or injectables or any prescription directing administration by injection (other than insulin) unless they are obtained through the specialty drug program through the Prescription Drug Vendor;
19. **Inpatient Prescription Drugs.** The Plan will not cover any medication which is to be taken by or administered, in whole or in part, while the Covered Person is a patient in a Hospital, a convalescent Hospital, rest home, sanitarium, Skilled Nursing Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
20. **Medicare.** The Plan will not cover expenses for which benefits are payable under Medicare Part A, Part B or Part D or would have been payable if a Covered Person had applied for Part A, Part B and/or Part D, except as specified in this Plan Document;
21. **No Charge.** The Plan will not cover charges for prescription drugs which may be properly received without charge under local, state or federal programs;
22. **Non-Covered Medical Condition.** The Plan will not cover any prescription drug services or charges for any condition not covered under the Medical Benefits;

23. **Morbid Obesity Treatment.** The Plan will not cover expenses intended primarily or partially for treatment or surgery for obesity, weight reduction or weight control. The Plan will not cover reversals of surgical treatment for Covered Persons diagnosed as having Morbid Obesity or complications from such care.
24. **Non-Covered Medication.** The Plan will not cover any medication that is not specifically listed as a Covered Prescription Drug under this Plan Document;
25. **Physician/Provider Administered Medication.** The Plan will not cover medication that is to be administered by a physician, nurse or anyone other than the patient in a normal home setting;
26. **Refills After One Year from Order.** The Plan will not cover any refill dispensed after one year from the Physician's original order;
27. **Smoking Cessation.** The Plan will not cover any prescription used for the treatment of smoking cessation;
28. **Termination Date.** The Plan will not cover any prescription filled or refilled after termination of Coverage; and
29. **Therapeutic Devices.** The Plan will not cover therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, insulin syringes or needles when prescribed alone and syringes or needles for other than diabetic use.

## GENERAL EXCLUSIONS

The following exclusions and limitations are the General Exclusions under the Plan and apply to the entire Plan.

1. **Applicable Section.** The Plan will not cover expenses which are payable under one section of this Plan under any other section of this Plan;
2. **Charges Incurred Due to Non-Payment.** The Plan will not cover charges for sales tax, mailing fees and surcharges incurred due to nonpayment;
3. **Claims Time Frames.** The Plan will not cover charges for claims not received within the Plan's filing limit deadlines as specified under the section entitled Claims Information.
4. **Controlled Substance.** The Plan will not cover charges for the care or treatment of an Illness or Injury resulting from the voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not administered by a Physician;
5. **Court Ordered Treatment.** The Plan will not cover charges for court ordered treatment not specifically mentioned as covered under this Plan;
6. **Criminal Act.** The Plan will not cover charges for services and supplies incurred as a result of an Illness or Injury, caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance;
7. **Effective and Termination Date.** The Plan will not cover charges for services and supplies for which a charge was incurred before the Covered Person was covered under this Plan or after their date of termination;
8. **Exclusions.** The Plan will not cover charges for services and supplies which are specifically excluded under this Plan;
9. **Experimental or Investigative.** The Plan will not cover charges for services or supplies which are either experimental or investigational or not Medically Necessary, except as provided herein;
10. **Excess of Provider's Allowable Charge.** The Plan will not cover charges for services and supplies for treatment which are in excess of the Provider's Allowable Charge (except as otherwise stated herein);
11. **Family Member.** The Plan will not cover expenses or services received from a member of the Covered Person's household or from an Immediate Family Member. For the purposes of this exclusion, Immediate Family Member means the Covered Employee, his or her spouse, brother, sister, parent or the Dependent Child. Immediate Family Member also includes the brother sister, parent or Dependent Child of the employee's spouse.
12. **Government Owned/Operated Facility.** The Plan will not cover charges for services and supplies in a hospital owned or operated by the United States government or any government outside the United States in which the Covered Person is entitled to receive benefits, except for the reasonable cost of services and supplies which are billed, pursuant to Federal Law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are eligible herein and which are not incurred during or from service in the Armed Forces of the United States or any other country;

13. **Hospital/Facility Employee.** The Plan will not cover charges for services billed by a Provider (Physician or nurse) who is an employee of a hospital or facility and is paid by the hospital or facility for the services rendered;
14. **Legal Obligation.** The Plan will not cover charges for services and supplies for which the Covered Person has no legal obligation to pay or for which no charge has been made;
15. **Maximum Benefit.** The Plan will not cover charges for services and supplies which exceed the maximum benefit, as shown in the Schedule of Benefits or Eligible Expenses;
16. **Military Related Disability.** The Plan will not cover charges for services and supplies for any military service-related disability or condition;
17. **Non-Medical Charges.** The Plan will not cover charges for: telephone consultations; failure to keep a scheduled visit; completion of a claim form; attending Physician statements; or requests for information omitted from an itemized billing;
18. **Non-Prescription Drugs.** The Plan will not cover charges for non-prescription drugs, except as otherwise stated herein;
19. **Not Under Care of Physician.** The Plan will not cover charges for services and supplies not recommended and approved by a Physician; or services and supplies when the Covered Person is not under the care of a Physician;
20. **Professional Medical Standards.** The Plan will not cover charges for services and supplies which are not provided in accordance with generally accepted professional medical standards or for experimental treatment;
21. **Subrogation Failure.** The Plan will not cover charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any party if the Covered Person fails to provide information as specified under Subrogation;
22. **Travel Outside the United States.** The Plan will not cover charges in connection with medical treatment received outside of the United States for an Eligible Retired Employee for which Medicare is primary, regardless of the Medical Necessity of the treatment.
23. **Travel Expenses.** The Plan will not cover charges for travel, whether or not recommended by a Physician, except as provided herein;
24. **War.** The Plan will not cover charges for services, supplies or treatment related to Illness, Injury, or disability caused by or attributed to an act of war, act of terrorism, riot, civil disobedience, insurrection, nuclear explosion or nuclear accident. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized military forces; and
25. **Work-Related Illness or Injury.** The Plan will not cover charges for the care and treatment of an Injury or Illness that is occupational, i.e., arises from work for wage or profit including self-employment, as described below, regardless of whether a Covered Person is covered by (or should have been covered by) any Workers' Compensation Act or other similar laws which may provide benefits for occupational Injury or Illness.

This exclusion applies not only to Injuries or Illness related to employment with or work for the Plan Sponsor but from any employment. Further, any care or treatments for any Injuries or Illness which are suffered in employment or self-employment, in which the employees/operators/participants are required by law to be covered by Workers' Compensation insurance (whether or not they are), will be excluded

from Coverage under this Plan. Care or treatments for any Injuries or Illness suffered by Dependent Children who work during breaks between school semesters or after school will not be excluded unless they are covered by Workers' Compensation insurance or similar laws providing benefits for the Injuries or Illnesses.

The exclusion for self-employment is limited, however, to self-employment which is: (1) performed for wage or profit, (2) reasonably substantial as to hours worked and services provided, (3) material as to the amount of compensation earned and (4) reasonably regular and continuous and not sporadic.

For example, treatments received as a result of Injuries suffered in self-employment:

1. In performing charitable work for which no compensation is received, would not be excluded because the activities are not for profit;
2. By a Dependent Child while working in self-employment (e.g., mowing lawns, power washing houses or cars, helping with a family business or farm) during summers or breaks between semesters in school, would not be excluded because the work is not continuous and may not be reasonably substantial;
3. By a Dependent Child while working after school, would not be excluded because the work probably is not reasonably substantial and may not be material or continuous;
4. By an adult Employee or Dependent while working occasional weekends or days off from regular employment in self-employment, for instance, in a tree trimming, landscaping, gardening, transport or light home repair or construction or other business, would not be excluded as long as the work is not reasonably substantial (i.e., does not require extensive commitments of time), is not material (i.e., does not provide substantial amounts of income) and is not continuous (i.e., is not pursued consistently but rather on some weekends or days off instead of nearly continuously on most available days).

Treatments received as a result of Injuries suffered during activities which are substantial, material and continuous such as running a farm or operating a construction business are excluded.

## **CLAIMS INFORMATION**

When the Covered Person receives Covered Services, a claim must be filed on the Covered Person's behalf to obtain benefits. In some cases, the Provider will file the claim for the Covered Person. If the Covered Person submits the claim, (s)he should use a claim form. It is in the Covered Person's best interest to ask the Provider if the claim will be filed on his or her behalf by the Provider.

### **CLAIM FORMS**

When the Covered Person is submitting the claim on his or her own behalf, (s)he may obtain a claim form from the Employer or Plan Sponsor. If forms are not available, send a written request for claim forms to HealthSCOPE Benefits. Written notice of services rendered may also be submitted to HealthSCOPE Benefits without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

1. Name of patient;
2. Patient's relationship to the Covered Employee;
3. Identification number;
4. Date, type and place of service;
5. Name of Provider; and
6. The Covered Person's signature and the Provider's signature.

### **TIMEFRAME FOR SUBMITTING CLAIM**

The claim form must be submitted within 12 months of receiving Covered Services and must have the data needed to determine benefits. An expense is considered incurred on the date the service or supply is given. Failure to submit the claim form within 12 months will not reduce any benefit if the Covered Person shows that the claim was submitted as soon as reasonably possible. No claim may be submitted later than one year after the usual 12-month filing period ends. The claim form should be submitted to the address shown on the Covered Person's identification card.

In the event of termination of the agreement between the Claims Administrator and the Plan Sponsor, all notices of claims for Covered Services received after the termination of such agreement should be provided to the Plan Sponsor.

### **CLAIMS REVIEW PROCEDURE**

This section describes the claims review procedures under the Plan. A claim is defined as any request for a benefit made by a Covered Person or by a Provider on behalf of the Covered Person that complies with the Plan's reasonable procedure for making a claim for benefits. The times shown in this section are maximum times only. A period of time begins at the time the claim is filed. The days shown in this section are counted as calendar days.

Under the Plan, the Covered Person can check on the status of a claim at any time by contacting the Customer Service number appearing on the Covered Person's identification card.

There are different time frames for reviewing a claim and providing notification concerning the claim. The time frames are based on the category of the claim. For the purpose of this provision, there are three categories of claims: Pre-Service Claims, Post-Service Claims and Urgent Care Claims.

**Pre-Service Claims** - Pre-Service Claims are those claims that require prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification, pre-authorization or pre-determination. For Pre-Service Claims (other than Urgent Care Claims), the following time frames apply concerning review and notification of the benefit determination:

1. **Notification Concerning Failure to Follow Procedure** - In the event the Covered Person, or Provider on behalf of the Covered Person, fails to follow the proper procedure for providing notification of a Pre-Service Claim, the Covered Person or Provider will be notified within 5 days.
2. **Benefit Determination Period** – The Covered Person will be notified of the benefit determination within 15 days following receipt of notification concerning the Pre-Service Claim.
3. **Extension of Benefit Determination Period** - If a benefit determination cannot be made within the standard 15-day benefit determination period due to matters beyond the Plan Administrator's control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 15-day benefit determination period. Only one extension is permitted for each Pre-Service Claim.

If a benefit determination cannot be made within the standard 15-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 15-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

**Urgent Care Claims** - Urgent Care Claims are those pre-service claims in which the time periods for making claim determinations for non-Urgent Care Claims could seriously jeopardize the Covered Person's life, health or ability to regain maximum function or when a Physician with knowledge of the Covered Person's medical condition determines that the Covered Person would be subject to severe pain that cannot be adequately managed or controlled without the treatment that is the subject of the claim. For Urgent Care Claims, the following time frame applies concerning review and notification of the benefit determination:

**Notification Concerning Incomplete Claim** - In the event the Covered Person, or Provider on behalf of the Covered Person, fails to submit complete information in connection with an Urgent Care Claim, the Covered Person or Provider will be notified of the specific information needed to complete the claim within 24 hours.

**Benefit Determination Period** – If the covered person has provided all of the necessary information the Covered Person will be notified of the benefit determination concerning an Urgent Care Claim within 24 hours following receipt of notification concerning the Urgent Care Claim.

**Extension of Benefit Determination Period** - In the event additional information is needed in order to make a benefit determination, the Covered Person must be notified within 24 hours following receipt of notification concerning the Urgent Care Claim. Notification of the extension will include a detailed explanation of the information needed to make the benefit determination.

**Benefit Determination Period For Request of Continuation of Treatment** - Any request to continue the course of treatment that is an Urgent Care Claim, shall be decided as soon as possible. The Covered Person will be notified of the benefit determination within 24 hours of the receipt of the claim, provided that such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

**Post-Service Claims** - Post-Service Claims are those claims for services, other than Pre-Service and Urgent Care Claims, that have been rendered by a Provider. For Post-Service Claims, the following time frames apply concerning review and notification of the benefit determination:

1. **Benefit Determination Period** - The Covered Person will be notified of the benefit determination within 30 days following receipt of notification concerning the Post-Service Claim.

2. **Extension of Benefit Determination Period** - If a benefit determination cannot be made within the standard 30-day benefit determination period due to matters beyond its control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 30-day benefit determination period. Only one extension is permitted for each Post-Service Claim.

If a benefit determination cannot be made within the standard 30-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 30-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

## **CLAIMS APPEAL PROCESS**

The Plan has a claims appeal process. The claims appeal process and the time limits associated with requesting and responding to a request for Claims Appeal are described in this section. The Covered Person and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office.

Under the Plan, the Covered Person can check on the status of a claim appeal at any time by contacting the Customer Service number appearing on the reverse side of the identification card.

**Requesting a Claims Appeal** - The Plan has a claims appeals process that allows the Covered Person to submit a request for appeal to the fiduciary who has been named by the Plan Administrator to review a claims appeal ("Named Fiduciary"). Under the Plan, the Plan Administrator will serve as the Named Fiduciary, unless the Plan Administrator has specifically delegated this responsibility to another party. The Named Fiduciary has the sole responsibility for making the decision on an appeal of an adverse benefit determination.

Under the claims appeal process, the Covered Person will be provided with a full and fair review of an adverse benefit determination. This review of an adverse benefit determination must be done by an individual who is neither the individual who made the original adverse benefit determination nor the subordinate of such individual. In addition, if the adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary, the Named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In the event the covered person disagrees with a claims decision concerning the denial of a benefit or scope of benefits, the covered person or the covered person's authorized representative may submit a request for appeal within 180 days from receipt of the notice of denial or adverse benefit determination. Absent an express written authorization by the covered person providing otherwise, the authorized representative includes a medical provider only for an Urgent Care Claims Appeal.

Under the claims appeal process:

1. The Covered Person is permitted to submit written documents, comments, records and other information relating to the claim;
2. The Covered Person is allowed reasonable access to any copies of documents, records and other information relevant to the claim;

3. The Covered Person is permitted to request the name of the medical provider used in making the initial adverse benefit determination; and
4. All comments, documents, records and other information submitted without regard to whether such information was submitted or considered in the initial determination will be taken into account.

The Covered Person's request for an appeal of an adverse benefit determination for Pre-Service and Post-Service Claims must be submitted in writing and should be submitted to the:

Conservation Employees' Benefits Plan Trust Fund c/o HealthSCOPE Benefits, Inc.  
P.O. Box 2860  
Little Rock, Arkansas 72203

For appeal of an Urgent Care Claim, the request for appeal may also be submitted verbally to the Conservation Employees' Benefits Plan Trust Fund by contacting 501-218-7865.

**If the Covered Person's request for appeal is not submitted to the Conservation Employees' Benefits Plan Trust Fund in the manner described in this section, it will not be considered a "claims appeal" under the Plan.**

Under this Plan, HealthSCOPE Benefits, Inc. is not the Named Fiduciary for purposes of reviewing claims appeals under the Plan, but is instead acting strictly at the request of the Plan Administrator to coordinate receipt of appeals on behalf of the Plan.

**Time Frame for Claims Appeal Review For Pre-Service Claim** - All Pre-Service Claim Appeals will be reviewed and written notification of the Conservation Employees' Benefits Plan Trust Fund's decision will be prepared and mailed to the Covered Person who submitted the claim appeal within 30 days of receiving the request for appeal of a Pre-Service Claim. As used in this section, a Pre-Service Claim Appeal is an appeal for any adverse claims determination in connection with a Pre-Service Claim.

**Time Frame for Claims Appeal Review for Urgent Care Claim** – If the *covered person* has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim.

If the *covered person* has not provided all of the information needed to process the claim, then the *covered person* will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.

**Time Frame for Claims Appeal Review For Post-Service Claim:** All Post-Service Claim Appeals will be reviewed and written notification of the Conservation Employees' Benefits Plan Trust Fund's decision will be prepared and mailed to the Covered Person who submitted the claims appeal within 60 days of receiving the request for appeal of a Post-Service Claim. As used in this section, a Post-Service Claim Appeal is an appeal for any adverse claims determination in connection with a Post-Service Claim.

Note: If the Plan Fiduciary is a multi-employer plan which has a committee or board of trustees designated as the appropriate Named Fiduciary which holds regular meetings (at least once a quarter), and if the appeal request is received within 30 days preceding the date of the next scheduled meeting, then the Named Fiduciary will make the determination concerning the claims appeal no later than the date of second meeting following receipt of the request. If special circumstances (such as the need to hold a hearing, if the Plan's procedures allow for such a hearing) require a further extension of time for processing an appeal request, a determination shall be rendered not later than the third meeting of the committee or board of trustees following the Plan's receipt of the request for review. In this instance, the Plan Administrator shall provide to the covered person written notification of the extension and such notice shall describe the special circumstances and the date as of which the determination will be made, prior to the commencement of the extension. The Covered Person will be notified of the Named Fiduciary's decision concerning the appeal no later than 5 days after the determination is made by Named Fiduciary.

**Notification of an Adverse Appeal Determination** - The *Plan Administrator* shall provide a *covered person* with a notice, either in writing or electronically (or, in the case of *pre-service urgent care claims*, by telephone, facsimile or similar method, with written or electronic notice), containing the following information:

1. The reason for the determination;
2. The reference to the specific plan provision(s) on which the benefit determination is based;
3. A statement that the Covered Person is entitled to receive free of charge access to and copies of documents and records pertinent to the claim;
4. A statement of the Covered Person's right to obtain free of charge, internal rules, guidelines, protocols, or other similar criterion used in making the adverse determination; and
5. Either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan, or a statement that such explanation may be obtained free of charge upon request if the claim was denied on the basis of Medical Necessity or Experimental or Investigative grounds.

#### **Decision on Review**

If, for any reason, the *covered person* does not receive a written response to the appeal within the appropriate time period set forth above, the *covered person* may assume that the appeal has been denied. Note that: **all claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 180 days after the Plan's claim review procedures have been exhausted.**

#### **External Review**

When a *covered person* has exhausted the internal appeals process outlined above, the *covered person* has a right to have that decision reviewed by independent health care professionals who has no association with the *Plan*, the *Plan Sponsor*, or the *Plan Administrator*. If the adverse benefit determination involved making a judgment as to the *medical necessity*, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, you may submit a request for external review within **4 months** after receipt of a denial of benefits to the Plan Sponsor, **Conservation Employees' Benefits Plan Trust Fund c/o HealthSCOPE Benefits, Inc., P.O. Box 2860, Little Rock, Arkansas 72203.**

For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of the denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is *experimental* or investigation, you also may be entitled to file a request for external review of our denial.

Please contact your *Plan Administrator* with any questions on your rights to external review.

## **PAYMENT OF BENEFITS**

The Covered Person may request that payments be made directly to a Provider; however, the Plan reserves the right to make payments to the Provider or directly to the Covered Person. The Covered Person cannot request that payment be directed to anyone else. Once a Provider renders a Covered Service, the Plan will not honor the Covered Person's request to withhold payment of the claims submitted.

If a benefit is owed when the Covered Person is not able to handle his or her affairs, the benefit may be paid to a relative by blood or marriage. This would happen if the Covered Employee had died or become mentally incompetent. The Plan will make payment to a relative whom it judged to be entitled in fairness to the money. Any such payment would discharge any obligation to the extent of such payment.

## **RIGHTS TO AN ITEMIZED BILL**

The Covered Person has the right to receive a copy of an itemized bill. This bill would identify the services and supplies rendered to the Covered Person. To receive a copy of the bill, send a written request to the Provider that rendered services. It is in the Covered Person's best interest to exercise this right so that (s)he has a copy of the bill for his or her personal files.

## COORDINATION OF BENEFITS, SUBROGATION AND THIRD PARTY RECOVERY

### COORDINATION OF BENEFITS PROVISION

All benefits provided as described in this Summary Plan Description are subject to Coordination of Benefits (COB). COB determines when a benefit plan is primary or secondary when a Covered Person is covered by more than one benefit plan.

This coordination of benefits provisions (“COB”) applies when the Covered Person is also covered by an Other Benefit Plan. When more than one coverage exists, one plan will pay its benefits in full according to the terms of that plan. The plan that pays its benefits in full is considered the primary plan. Any Other Benefit Plan is referred to as the secondary plan and pays a reduced benefit to prevent duplication of benefits.

By coordinating benefits under this provision, the total benefits payable by all Other Benefits Plans and this Plan will not exceed 100% of Allowable Expenses, as defined herein. A common set of rules is used to determine the order of benefits determination.

When the Plan is primary, the Plan will pay benefits without regard to any Other Benefit Plan. When this Plan is secondary, the benefits payable under this Plan will be reduced so that the sum of benefits paid by all Other Benefits Plans and this Plan do not exceed 100% of total Allowable Expenses.

**Definitions:** As used in this section, the following terms are defined as:

“Other Benefit Plan” means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

“Allowable Expenses” means any Eligible Expenses incurred while the Covered Person is covered under this Plan, except that any Eligible Expenses incurred that apply toward the Covered Person’s copayment, deductible or coinsurance requirement under this Plan or any Other Benefit Plan will not be included as an Allowable Expense.

**Automobile Limitations:** When medical payments coverage is available under the vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles or other out-of-pocket requirements under the vehicle plan. This Plan shall always be considered secondary regardless of the Covered Person’s election under PIP (personal injury protection) or any no-fault coverage with the automobile carrier.

**Motor-Vehicle Related Injury:** The Plan will not cover the cost of health care expenses resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent that such services or expenses are payable under any Personal Injury Protection, no-fault, medical payments provision, or any other category (including such benefits mandated by law) of any automobile or vehicle insurance plan.

### ORDER OF BENEFITS DETERMINATION (OTHER THAN MEDICARE)

Which plan provides primary or secondary Coverages will be determined by using the first of the following rules that applies:

1. **No COB.** If the Other Benefit Plan contains no COB provision, it will always be primary.
2. **Employee or Member.** The benefit plan covering the Covered Person as an employee, member or subscriber (other than a Dependent) is primary.

3. **Medicare Eligible.** If a Covered Person is eligible for Medicare, benefits will be coordinated with Medicare as set forth in the section entitled “Order of Benefits Determination for Medicare.”
4. **Dependent Child of Parents (Not Divorced or Legally Separated).** When a Dependent is covered by more than one plan of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary. If both parents have the same birthday, the plan that covered the parent longer will be primary. If a Dependent is covered by two benefit plans and the Other Benefit Plan does not have coordinate benefits based on the birthday of the parent (e.g., benefits are coordinated based on the gender of the parents), the rule of the Other Benefit Plan will determine the primary and secondary contract.
5. **Dependent Child of Parents Divorced or Legally Separated.** When a Dependent is covered by more than one plan of different parents who are separated or divorced, the following rules apply:
  - a. If the parent with custody has not remarried, his or her coverage is primary;
  - b. If the parent with custody has remarried, his or her coverage is primary, the stepparent's is secondary and the coverage of the parent without custody pays last; or
  - c. If a court decree specifies the parent who is financially responsible for the Child's health care expenses, the coverage of that parent is primary.
6. **Active Employees vs. Laid Off or Retired Employees.** When a plan covers the Covered Person as an active employee or a Dependent of such employee and the Other Benefit Plan covers the Covered Person as a laid-off or retired employee or as a Dependent of such person, the plan that covers the Covered Person as an active employee or Dependent of such employee is primary.
7. **Above Rules Do Not Apply.** When the rules above do not apply, the plan that has covered the Covered Person longer is primary.
8. **Special Note about Continued Coverage.** If the Covered Person is covered under an Other Benefit Plan that is primary but also has continued Coverage under this Plan (e.g., COBRA) due to the Other Benefit Plan's pre-existing condition exclusion, then this Plan will be primary for expenses incurred in connection with such pre-existing condition only.

## ORDER OF BENEFITS DETERMINATION FOR MEDICARE

For individuals who are Medicare eligible (e.g. individuals who are Medicare eligible due to age or disability) Medicare will pay primary, secondary or last to the extent dictated by the Medicare Secondary Payer rules and any other applicable federal statutory or regulatory requirements. When Medicare is to be the primary payer, this Plan will base payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. Refer to the following section entitled “Medicare Payer Rules” for additional details.

### MEDICARE PAYER RULES

For individuals who are Medicare eligible (e.g. individuals who are Medicare eligible due to age or disability) Medicare will pay primary, secondary or last to the extent dictated by the Medicare Secondary Payer rules and any other applicable federal statutory or regulatory requirements. Refer to the following for detail.

## **Medicare Eligibility On The Basis of Age**

Under Medicare, Medicare is the secondary payor for the Working Aged. As used herein, the Working Aged include an employee age 65 or over and the employee's spouse who is age 65 and over, who have coverage under a group health plan because of the employee's or spouse's employment. This provision applies to employer-sponsored health plans that have 20 or more full time or part-time employees for each working day in each of 20 more calendar weeks in the current calendar or preceding calendar year. Based on this provision, the Covered Employee's Plan will be considered primary for the employee and his/her spouse as long as such employee remains Actively Working, and the Plan will not reduce or terminate Coverage of such employees and their spouses because of their entitlement to Medicare.

Medicare allows the Covered Employee or spouse to choose Medicare as primary. In this event, the employee and Spouse will lose Coverage under the Plan for any benefits that would be considered Medicare eligible expenses. Additionally, an employee or spouse who elects Medicare as the primary payor may purchase a Medicare supplement plan from a source other than the Employer. The Employer may not purchase or subsidize an individual Medicare supplement plan for the employee or spouse.

This provision does not apply if the Covered Employee or Spouse is a COBRA beneficiary. In this instance, Medicare will be the primary payer and the Plan will be the secondary payer.

## **Medicare Eligibility Due to Kidney Failure**

Medicare is the secondary payer if the Covered Person has Medicare due to permanent kidney failure for the first 30 months following the date of eligibility or Medicare entitlement; as such date is determined by Medicare.

After a period of up to 30 months following the expiration of this date, Medicare will become the primary payer. Once Medicare becomes primary, the benefits of the Plan will be applied only to any unpaid balance after the Covered Person receives Medicare benefits. In this event, Medicare benefits available to the Covered Person will be subtracted whether or not a Medicare claim is filed.

This provision will also apply if the Covered Person is a COBRA beneficiary.

## **Medicare Eligibility Due to Other Disability**

Medicare is the secondary payer for people under age 65 who have Medicare because of a disability (other than those with permanent kidney failure) and who are covered under a Large Group Health Plan as an employee or Dependent of such person. To be eligible under this provision, the employee must be Actively Working in spite of the disability.

This provision does not apply if the Covered Person is a COBRA beneficiary. In this instance, Medicare will be the primary payer and the Plan will be the secondary payer.

## **Medicare Eligibility for Retirees**

For Eligible Retired Employees who are enrolled for Medicare, Medicare will be determined the primary payer and the Plan will be considered the secondary payer. This means that Medicare benefits will be determined first and the benefits under the Plan will be applied only to any unpaid balance after Medicare benefits are received. If the Covered Person is eligible for Medicare, but has not enrolled for Medicare or filed a Medicare claim, Plan benefits will be reduced by any benefits that would have been paid under Medicare had the person enrolled for Medicare or filed a Medicare claim.

**Note:** The Plan will not cover charges in connection with medical treatment received outside of the United States for an Eligible Retired Employee for which Medicare is primary, regardless of the Medical Necessity of the treatment.

### **THIRD PARTY RECOVERY**

The Plan has the right to recover from Covered Persons and Others certain proceeds received or receivable by Covered Persons as described below. As a condition precedent to receipt of coverage and benefits under this Plan, each Covered Person who accepts such coverage or benefits, and their spouses, dependents, estates and personal representatives, agree to the following.

**Right of Recovery.** When a Covered Person is injured, becomes disabled or incurs an illness and the Plan pays for medical treatments and services incurred because of such illness, disability or injury and an Other Party is financially responsible for or liable to the Covered Person for injuries, disabilities or illness suffered and incurred by the Covered Person and the Covered Person obtains or has the right to obtain a Recovery from the Other Party that is responsible or financially liable for the damages caused by the injury or illness, then the Plan and Department shall be entitled to recover from the Covered Person, the Other Party and the Recovery all amounts that the Plan and Department have paid as a result of such injury or illness.

“Other Party” is any individual, insurance company or some other public or private entity who is liable or financially responsible for the injury, illness or disability.

“Recovery” includes any payments through judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from a tortfeasor, a liability insurer for a tortfeasor, or any other source or Other party (including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, or any other form of insurance coverage) made to or on behalf of a Covered Person, his or her spouse, dependents, estate or personal representatives, for or as a result of any injury, disability or illness to the extent of payments made by the Plan or Department for medical treatments or services incurred because of the injury, disability or illness for which the Recovery is being paid.

Under Missouri law, the amounts paid by the Plan for such injuries or illnesses constitute a debt payable by the Participant or Other Party. Before the Plan and Department may receive any Recovery, the Department shall satisfy any attorney’s lien for fees is satisfied pursuant to settlement or proceeding as described in Mo. Rev. Stat. §208.215.

**Direct Action and Assignment.** By accepting coverage and benefits under this Plan, every Covered Person (and their spouse, dependents, estate, etc.) assigns his or her rights of Recovery to the Plan and Department. The Plan and Department may bring a direct action in tort, contract or equity, including an action for wrongful death, in its name and/or the name of the Plan against any Other Party to recover funds that it has paid in these circumstances.

**Duty to Cooperate.** All Persons must cooperate fully and provide all information needed under the Plan and Department to obtain Recoveries and execute any papers necessary to obtain such Recoveries. Any Covered Person who has notice or knowledge of the Plan’s and Department’s rights to Recoveries or who receives any Recovery must pay the Recovery to the Plan or Department within sixty days after receipt or place the Recovery in a trust account for the benefit of the Plan pending legal determination of ownership rights. The Plan may require the Covered Person, as a pre-condition to receiving benefit payments, to sign such agreements and to agree in writing to assist the Plan to secure the Plan’s right to Recovery.

**Lien.** In addition to the foregoing and in exchange for coverage and benefits provided under the Plan, the Plan and Department shall have a lien upon any Recovery obtained or to be obtained by a Covered Person their spouse or dependents, estate or personal representative, may obtain or be entitled to obtain as a result of any claim for injuries, disability or disease benefits, to the extent that the Plan and/or Department made payment for medical expenses or services incurred because of illness, injury or disability. This lien will also apply to any Recovery that may come into the possession of any attorney who is handling such claim.

A lien notice will be served by certified mail or registered mail, upon the Other Party against whom the Covered Person may have a claim, demand or cause of action and the notice will describe the claim that the Plan and Department have against such Recovery and the claim. The lien will attach to any verdict or judgment entered and to any money or property which may be recovered.

The Plan and Department will also have all rights provided under Missouri law including those specified at Mo. Rev. Stat. §§ 376.433 and 208.215.

## **COBRA CONTINUATION COVERAGE**

A federal law commonly referred to as COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of benefit ("COBRA Continuation Coverage") at group rates in certain instances where Coverage under the Plan would otherwise end. This notice is intended to inform the Covered Person, in a summary fashion, of the rights and obligations under the COBRA Continued Coverage provisions of the law. If the Covered Person does not choose COBRA Continuation Coverage, the Coverage under the Plan will end.

COBRA Continuation Coverage applies to the medical benefits under the Plan and also applies to any dental and/or vision coverage if covered under the Plan prior to the Qualifying Event. The Covered Person will only be entitled to receive COBRA Continuation Coverage for the coverage(s) (s)he elects to continue during the election process as described herein.

### **Qualified Beneficiaries**

As used herein, a Qualified Beneficiary is a Covered Person who loses Coverage under the Plan as the result of a Qualifying Event.

### **Qualifying Events**

Qualifying Events are any one of the following events, which would normally result in termination of Coverage. These events will qualify a Covered Person to continue coverage as a Qualified Beneficiary beyond the termination date described in the Plan Document. The Qualifying Events are listed below.

1. Death of the Covered Employee.
2. The Covered Employee's termination of employment (other than termination for gross misconduct) or reduction in work hours to less than the minimum required for Coverage under the Plan. This includes Covered Employees whose employment has been terminated following the last day of leave under the Family and Medical Leave Act.
3. Divorce or legal separation from the Covered Employee.
4. The Covered Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A Dependent child no longer meets the eligibility requirements of the Plan.
6. A covered Retiree and their covered Dependents whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.

### **Notification Requirements**

There are a number of notification requirements under COBRA. First, the Plan Administrator must be alerted to a Qualifying Event in order to offer COBRA Continuation Coverage to Qualified Beneficiaries. This notice must be submitted in writing to the Plan Administrator, either by the Employer, or by the Covered Employee or a Dependent. The nature of the Qualifying Event determines which party must notify the Plan Administrator. Second, once the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will provide notices to the COBRA Beneficiary. The notification requirements established under COBRA are described in this COBRA Continuation Coverage section.

## **Notification by Covered Employee or Dependent**

The Covered Employee or Dependent must notify the Plan Administrator when eligibility for COBRA Continuation Coverage results from one of the following events:

1. Divorce or legal separation from the Covered Employee; or
2. A Dependent child no longer meets the eligibility requirements of the Plan.

The Covered Employee or Dependent must provide this notice to the Plan Administrator within 60 days of either the Qualifying Event or date of loss of Coverage, as applicable to the Plan.

For individuals who are requesting an extension of COBRA Continuation Coverage due to a disability, the individual person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial 18-month COBRA Continuation Coverage period and no later than 60 days after the Social Security Administration's determination. When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within 30 days of such change in status.

These notification requirements also apply to an individual who, while receiving COBRA Continuation Coverage, has a second or subsequent Qualifying Event. Refer to the section entitled "Period of Continued Coverage" for additional information.

The Covered Employee or Dependent, or their representative, must deliver this notice **in writing** to the Plan Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted. If the requested information is not provided within the time limit set forth above the Plan Administrator reserves the right to reject the deficient notice, which means that the individual has forfeited their rights to COBRA Continuation Coverage.

To protect their rights, it is very important that Covered Employees and Dependents keep the Plan Administrator informed of their current mailing address. Any notices will be sent to individuals at their last known address. It is the responsibility of Covered Employees and Dependents to advise the Plan Administrator of any address changes in a timely manner, in order to ensure that notices, such as those regarding their rights under COBRA, are deliverable.

Failure to provide notice to the Plan Administrator in accordance with the provisions of this notice requirement will result in the person forfeiting their rights to COBRA Continuation Coverage under this provision.

## **Notification by Employer**

The Employer is responsible for notifying the Plan Administrator when eligibility for COBRA Continuation Coverage results from any events other than divorce or legal separation, or a Dependent becoming ineligible.

The Employer shall provide this notice to the Plan Administrator within thirty (30) days of either the Qualifying Event or date of loss of coverage, as applicable to the Plan. The Employer must include information that is sufficient to enable the Plan Administrator to determine the Plan, the Covered Employee, the Qualifying Event, and the date of the Qualifying Event.

The Employer must deliver this notice **in writing** to the Plan Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that

any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted.

### **Notification by Plan Administrator**

**Election Notice:** Once the Plan Administrator receives proper notification that a Qualifying Event has occurred, COBRA Continuation Coverage shall be offered to each of the Qualified Beneficiaries by means of a COBRA Election Notice. The time period for providing the COBRA Election Notice shall generally be 14 days following receipt of notice of the Qualifying Event. This time period may be extended to 44 days under certain circumstances where the Employer is also acting as the Plan Administrator.

**Notice of Ineligibility:** In the event that the Plan Administrator determines that the Covered Employee and/or Dependent(s) are not entitled to COBRA coverage, the Plan Administrator shall notify the Covered Employee and/or Dependent(s). This notice shall include an explanation of why the individual(s) may not elect COBRA Continuation Coverage. A notice of ineligibility shall be sent within the same time frame as described for a COBRA Election Notice.

**Notice of Early Termination:** The Plan Administrator shall provide notice to a Qualified Beneficiary of a termination of COBRA Continuation Coverage that takes effect on a date earlier than the end of the maximum period of COBRA Continuation Coverage that is applicable to the Qualifying Event. The Plan Administrator shall notify the Qualified Beneficiary as soon as possible after determining that coverage is to be terminated. This notice shall contain the reason coverage is being terminated, the date of termination, and any rights that the individual may have under the Plan, or under applicable law, to elect alternative group or individual coverage.

### **Election Of Coverage**

Upon receipt of Election Notice from Plan Administrator, a Qualified Beneficiary has 60 days from the date the notice is sent to decide whether to elect COBRA Continuation Coverage. Each person who was covered under the Plan prior to the Qualifying Event has a separate right to elect COBRA Continuation Coverage on an individual basis, regardless of family enrollment. For example, the employee's spouse may elect COBRA Continuation Coverage even if the employee does not select the coverage. COBRA Continuation Coverage may be elected for one, several or all dependent children who are Qualified Beneficiaries and a parent may elect COBRA Continuation Coverage on behalf of any dependent child.

In considering whether to elect COBRA Continuation Coverage, the Qualified Beneficiary should take into account that a failure to continue coverage may affect future rights under federal law. For example, the Covered Person may lose the right to be provided with a reduction in a pre-existing condition limitation if the gap in coverage is greater than 63 days. The Covered Person also has special enrollment rights under HIPAA which allow him or her to enroll in another group health plan for which (s)he is otherwise eligible when Coverage under this Plan terminates due to a Qualifying Event. The Covered Person also has the same special enrollment rights at the end of the COBRA Continuation Coverage if (s)he receives continued coverage for the maximum period available under COBRA.

If the Qualified Beneficiary chooses to have continued coverage, (s)he must advise the Plan Administrator in writing of this choice. This is done by submitting a written COBRA Election Notice to the Plan Administrator. The Plan Administrator must receive this written notice no later than the last day of the 60-day period. If the election is mailed, the election must be postmarked on or before the last day of the 60-day period. This 60-day period begins on the later of the following:

1. The date coverage under the Plan would otherwise end; or
2. The date the notice is sent by the Plan Administrator notifying the person of his or her rights to COBRA Continuation Coverage.

## **Second Election Period for TAA-Eligible Covered Employees**

Covered Employees, whose employment is terminated and who become entitled to receive trade adjustment assistance (TAA) in accordance with the Trade Act of 1974 are provided a second 60-day COBRA election period. TAA-eligible individuals who did not elect COBRA Continuation Coverage during the initial sixty day COBRA election period, which followed the TAA-related loss of coverage, may elect COBRA Continuation Coverage during the 60-day period that begins on the first day of the month in which the individual is determined to be eligible for TAA, provided this election is made no later than 6 months after the date of the TAA-related loss of coverage. Any COBRA Continuation Coverage elected during the second election period shall be effective on the first day of the second election period, and not on the date on which Coverage originally lapsed. The time between the loss of Coverage and the start of the second election period shall not be counted for purposes of determining whether the individual has had a 63-day break in Creditable Coverage with regard to application of any Pre-existing Condition limitation.

## **Period Of Continued Coverage**

The law requires that a Qualified Beneficiary who elects COBRA Continuation Coverage be afforded the opportunity to maintain COBRA Continuation Coverage for 36 months unless (s)he loses Coverage under the Plan because of a termination of employment or reduction in hours. In that case, the required COBRA Continuation Coverage period is 18 months.

This 18-month period may be extended if a subsequent or second Qualifying Event (for example, divorce, legal separation, an employee's becoming entitled to Medicare or death) occurs during that 18-month period. A second event may be a valid Qualifying Event only if it would have been a valid first Qualifying Event. That is, a second Qualifying Event shall qualify only if it would have caused a Covered Person to lose Coverage under the Plan if the first Qualifying Event had not occurred. A second or subsequent Qualifying Event is therefore limited to the following Qualifying Events:

1. Death of a Covered Employee;
2. Divorce or legal separation between the spouse and the Covered Employee; and
3. Dependent Child's loss of Dependent status under the Plan.

The Covered Employee's Medicare entitlement may also be considered a subsequent or second Qualifying Event for any Dependents who are Qualified Beneficiaries following the first Qualifying Event, but only if the Medicare entitlement would have resulted in loss of Coverage under the Plan had the first Qualifying Event not occurred.

Under no circumstances, however, will Coverage last beyond 36 months from the date of the event that originally made the Covered Person eligible to elect Coverage. Only a person covered prior to the original Qualifying Event or a child born to or Placed for Adoption with a Covered Employee during a period of COBRA continuation is eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event. Any other Dependent acquired during COBRA Continuation Coverage is not eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event.

## **Period of Continued Coverage for Disabled Person**

A person who is totally disabled may extend COBRA Continuation Coverage from 18 months to 29 months. Non-disabled family members may also elect to extend COBRA Continuation Coverage even if the disabled individual does not elect to extend his coverage.

The disabled person must be disabled for Social Security purposes at the time of the Qualifying Event or within 60 days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial 18-month COBRA Continuation Coverage period and no later than 60 days after the latest of the following:

1. The date of the Social Security Administration's determination;
2. The date of the Qualifying Event;
3. The date the Qualified Beneficiary would lose Coverage under the plan; or
4. The date the Qualified Beneficiary is informed of the obligation to provide the disability notice, either through this Plan Document or the initial COBRA Notice provided by the Employer.

Refer to the guidelines set forth in the subsection entitled "Notification by Covered Employee or Dependent."

When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within 30 days of such change in status.

## **Cost of Coverage and Payments**

The Plan requires that Qualified Beneficiaries pay the entire costs of their COBRA Continuation Coverage, plus a two percent administrative fee. This must be remitted to the Employer or the Employer's designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

The premium for an extended COBRA Continued Coverage period due to a total disability may also be higher than the premium due for the first 18 months. If the disabled person elects to extend coverage the Employer may charge 150% of the contribution during the additional 11 months of COBRA Continuation Coverage. If only the non-disabled family members elect to extend coverage the Employer may charge 102% of the contribution.

For purposes of determining monthly costs for continued coverage, a person originally covered as an Employee or as a spouse will pay the rate applicable to a Covered Employee if Coverage is continued for himself alone. Each child continuing Coverage independent of the family unit will pay the rate applicable to a Covered Employee.

Timely payments must be made for the continued Coverage. The initial payment must be made within 45 days after the date the person notifies the Employer that he has chosen to continue Coverage. The initial payment must be the amounts needed to provide Coverage from the date continued benefits begin, through the date of election.

Thereafter, payments for continued Coverage are to be made monthly. These monthly payments are due on the first day of each month. If the premium is not received by the first day of the month, the Employer will consider that Coverage has been allowed to terminate until the monthly payment has been received. However, a 30-day grace period is allowed for receipt of this monthly payment before the termination becomes final. Claims will be denied until the monthly premium payment is received.

There shall be no grace period for making payments, other than the grace period described above.

If the initial payment, or any subsequent monthly payment, received is short by an insignificant amount (the lesser of \$50 or 10% of the premium), the Covered Person will be sent a notice at the Covered Person's last known address stating that the remaining amount due must be sent within 30 days to continue Coverage under COBRA if the Plan Administrator requires the payment to be made in full. The Plan Administrator may also choose to accept the payment, which was short by an insignificant amount, as payment in full. Should a Covered Person have any questions in regards to how payment short by an insignificant amount will be handled under this Plan, please contact the Plan Administrator.

### **When Continuation Coverage Begins**

When COBRA Continuation Coverage is elected and the contributions paid within the time period required coverage is reinstated back to the date of the Qualifying Event or loss of coverage, as applicable to the Plan, so that no break in Coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

### **Dependents Acquired During Continuation**

A spouse or Dependent child newly acquired during COBRA Continuation Coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during COBRA Continuation Coverage. A Dependent acquired and enrolled after the original Qualifying Event, other than a child born to or Placed for Adoption with a Covered Employee during a period of COBRA Continuation Coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of Coverage.

### **End Of COBRA Continuation Coverage**

COBRA Continuation Coverage will end on the earliest of the following dates:

1. 18 months from the date continuation began because of a reduction of hours or termination of employment of the Covered Employee;
2. 36 months from the date continuation began for Dependents whose coverage ended because of the death of the Covered Employee, divorce or legal separation from the Covered Employee, the child's loss of Dependent status, or Medicare entitlement;
3. The end of the period for which contributions are paid if the Covered Person fails to make a payment on the date specified by the Employer or by the end of the grace period;
4. The date coverage under this Plan ends and the Employer offers no other group health benefit plan;
5. The date the Covered Person first becomes entitled to Medicare after the COBRA election;
6. The date the Covered Person first becomes covered under any other group health plan without regard to a pre-existing condition after the COBRA election. If the replacing group health plan has a pre-existing condition limitation, the Covered Person may remain covered under the Plan until he or she has satisfied the pre-existing condition limitation under the new group health plan, or until he or she is no longer eligible under the COBRA Continuation Coverage, as set forth herein;

7. The date the Covered Person is terminated from the Plan for cause, provided an active Covered Employee would be terminated under the Plan for the same cause; or
8. 36 months from the date continuation began for the surviving spouse and Dependent children of a Retiree who dies, when the Retiree's Qualifying Event was the Employer's bankruptcy filing.

The Plan Administrator shall provide notice of any early termination. Refer to subsection "Notification Requirements, Plan Administrator."

The COBRA law also requires that an individual who has elected COBRA Continuation Coverage be permitted to enroll in any individual conversion health plan which is provided under the Plan. Contact the Plan Administrator about the availability of a conversion policy.

### **The Plan Administrator and Contact Information**

An employee may obtain additional information about his or her COBRA Continuation of Coverage rights from the Plan Administrator. If the employee has any questions concerning his or her COBRA Continuation of Coverage rights, or if (s)he wants a copy of the Plan Document, (s)he should contact the Plan Administrator.

Finally, in order to protect the employee's and his or her family's rights, the Covered Person should keep the Plan Administrator informed of any changes to his or her address and the addresses of family members. The employee should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

The name, address and telephone number of the Plan Administrator is:

**The Conservation Employees' Benefits Plan Trust Fund  
P.O. Box 507, Jefferson City, Missouri 65102-0507  
2901 W. Truman Blvd., Jefferson City, Missouri 65109  
(573) 751-4115**

It is important to note that the Plan Administrator has contracted with HealthSCOPE Benefits, Inc. to perform certain COBRA services on behalf of the Plan. Therefore, the employee may also contact HealthSCOPE Benefits, Inc. if (s)he has questions about COBRA Continuation Coverage or wishes to inquire about his or her COBRA continuation rights. The address and telephone number for HealthSCOPE Benefits, Inc. is:

**HealthSCOPE Benefits, Inc.  
27 Corporate Hill Drive  
Little Rock, Arkansas 72205  
(501) 225-1551**

## **GENERAL PROVISIONS**

### **ADMINISTRATION OF THE PLAN**

The Plan is administered through the Conservation Employees' Benefits Plan Trust Fund. The Missouri Department of Conservation is the Employer and Plan Sponsor. The Conservation Employees' Benefits Plan Trust Fund, as the Plan Administrator, shall have full charge of the operation and management of the Plan. The Missouri Department of Conservation has retained the services of HealthSCOPE Benefits to administer the benefits described in this Plan Document.

The Conservation Employees' Benefits Plan Trust Fund shall also function as the Plan Fiduciary unless the Missouri Department of Conservation appoints another individual or entity to act in this capacity. Refer to the section entitled "Operation and Administration of the Plan" for more details concerning the administration of the Plan.

### **ALTERATION OF APPLICATION**

An enrollment application may not be altered by anyone other than the applicant unless the applicant has given his or her written consent allowing alterations.

### **AMENDMENT OF THE PLAN**

**Amendment:** The Conservation Employees' Benefits Plan Trust Fund reserves the right to amend this Plan at any time by an instrument duly executed by an authorized officer. Such amendment shall be binding upon the Conservation Employees' Benefits Plan Trust Fund and all Covered Persons. The Conservation Employees' Benefits Plan Trust Fund shall furnish to each Covered Employee a summary, written in a manner calculated to be understood by the average Covered Employee, of any modification to the Plan or change in the information required to be included in the Plan Document.

**Retroactive Amendments:** An amendment to this Plan may be made retroactively effective so long as it does not adversely affect the rights of Covered Persons to benefits under this Plan for covered health care expenses which are incurred after the effective date of the amendment but before the amendment is adopted.

**Material Reduction:** Amendments that are a material reduction in Covered Services or benefits must be disclosed not later than 60 days after the date of adoption of the modification or change. A "material reduction in covered services or benefits" means any modification to the plan or change in the information required to be included in the Plan Document that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average Covered Employee to be an important reduction in Covered Services or benefits under the Plan. A "reduction in covered services or benefits" generally would include any Plan modification or change that: eliminates benefits payable under the Plan; reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, Deductibles, Coinsurance, Copayments, or other amounts to be paid by a Covered Employee.

### **APPLICABLE LAW**

This Plan shall be construed in accordance with the laws of the State of Missouri and of the United States of America. Any provision of this Plan that is in conflict with applicable law is amended to conform with the minimum requirements of that law.

### **ASSIGNMENT OF BENEFITS**

No assignment of the Plan, or any rights or benefits under the Plan, shall be valid unless permitted under the terms of the Plan or the Plan Sponsor has consented to such assignment in writing.

The Plan will pay benefits under this Plan to the Covered Employee unless payment has been assigned to a

Hospital, Physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the Claims Administrator is notified in writing of such assignment prior to payment hereunder.

### **BENEFITS NOT TRANSFERABLE**

Except as otherwise stated herein, no person other than an eligible Covered Person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

### **COSTS AND EXPENSES**

The costs and expenses incurred in the administration of this Plan shall be paid from the Plan, unless paid by the Employer. In addition, the Employer may require that Covered Employees contribute toward the cost of the Plan. Such contributions shall be paid to the Plan or used to pay premiums due on insurance policies held by the Plan. Benefits under this Plan shall be paid from such policies or from the contributions paid to the Plan. In addition, administrative expenses, including but not limited to expenses for claims, administration fees and costs, fees, accountants, legal counsel and consultants and advisers, bonding expenses, and other costs of administering the Plan shall be included in such contributions.

### **COUNTERPARTS**

This Plan may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together constitute one instrument, which may be sufficiently evidenced by any counterpart.

### **EFFECTIVE DATE**

Except where specifically stated otherwise in this Plan, the provisions of this amended and restated Plan are effective January 1, 2007 and this Plan Document shall supersede and replace all prior versions of the Plan as of that date.

### **EMPLOYMENT RIGHTS**

The establishment of the Plan and the Covered Employee's participation in the Plan does not affect in any way the Covered Employee's employment rights. Nor does the establishment of, or employee's participation in, such Plan confer any right upon any employee to be retained in the service of the Employer.

### **ERRONEOUS INFORMATION**

If any information pertaining to any Covered Person is found to have been reported erroneously to the Plan Sponsor or to HealthSCOPE Benefits, as the claims administrator, and such error affects his or her Coverage, the facts will determine to what extent, if any, the Covered Person was or is covered under the Plan.

### **EXCLUSIVE BENEFIT**

This Plan is established and shall be maintained for the exclusive benefit of the Covered Persons.

### **EXEMPTION FROM ATTACHMENT**

To the full extent permitted by law, all rights and benefits under the Plan are exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Covered Employee or other Covered Person.

## **FREE CHOICE OF HOSPITAL AND PHYSICIAN**

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to make a free choice to select a Hospital, Professional Provider or other Provider of health care services. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have higher out-of-pocket expenses if the Covered Person uses the services of a Non-Preferred Provider.

## **INCONTESTABILITY**

All statements made by the Employer or by the Covered Employee shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the Employer or by the Covered Person, as the case may be. A statement made shall not be used in any legal contest unless such statement is made in writing and signed by such person and a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

## **INCORPORATION OF APPLICABLE INSURANCE CONTRACTS**

The benefits may also be governed by the provisions of certain insurance contracts purchased on behalf of the Plan. All such insurance contracts, if any, as the same may be amended from time to time, are hereby incorporated herein by this reference and made a part of this Plan.

## **INTEREST IN PLAN ASSETS**

Except with respect to the right of a Covered Person to receive benefits under this Plan, no employee or any other person shall have any right, title or interest in or to the assets of the Plan or in or to any contributions thereto, such contributions being made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms. Neither the Employer, the Board of Trustees, nor the Claims Administrator in any way guarantees the Plan from loss or depreciation, nor guarantees the payment of any benefits that may be or become due to any person under the Plan. The liability of the Employer and the Board of Trustees for payment of benefits under the Plan as of any date is limited solely to the then assets of the Plan. The liability of the Claims Administrator for the administration of claims under the Plan as of any date is limited solely to the funds have been provided by the Plan for the express purpose of funding claims or as of that date. Any unclaimed property will remain an asset of the Plan and will not be forfeited to the state.

## **INTERPRETATION OF PLAN PROVISIONS**

All provisions of this Plan shall be interpreted and administered in accordance with the provisions of applicable law in a non-discriminatory manner and in a manner that will assure compliance of the Plan's operation therewith. All persons in similar circumstances shall receive uniform, consistent, and non-discriminatory treatment hereunder.

## **LEGAL ACTIONS**

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of 60 days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of 3 years from the date the expense was incurred.

## **LIABILITY AND LIMITATION OF ACTION**

This Plan will not give the Covered Person any claim, right, action or cause of action against any person or entity other than the Provider rendering Covered Services to the Covered Person for acts or omissions of such Provider.

Except with respect to the right of a Covered Person to receive benefits under this Plan, no Covered Person shall have any right to or interest in the assets of or contributions to the Plan. Such contributions are being made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms.

The Plan Sponsor and HealthSCOPE Benefits do not actually furnish health care services as described in this Plan Document. Rather, Coverage will be provided for the health care services covered under the Plan when rendered by a Provider to the Covered Person.

## **PHYSICAL EXAMINATION AND AUTOPSY**

By accepting Coverage, as described in this Plan Document, the Covered Person agrees that (s)he may be required to have one or more physical examinations. Performance of an autopsy may also be required in the case of death where it is not forbidden by law. These examinations and/or autopsy will help to determine what benefits will be payable, particularly when there are questions concerning services on a claim.

## **PLAN RIGHT TO RECOVERY**

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, according to the terms of the Plan, the Plan will have the right to recover these excess payments. Whenever payments have been made from the Plan that should not have been made, according to the terms of the Plan, the Plan will have the right to recover these incorrect payments. The Plan has the right to recover any such overpayment or incorrect payment from the person or entity to whom payment was made, or from any other appropriate party, whether or not such payment was made due to the Plan Administrator's own error.

## **REVERSION OF ASSETS**

No part of the Plan assets shall revert to the Employer, or be used for, or diverted to, purposes other than the provision of welfare benefits as described herein for the exclusive benefit of Covered Employees.

## **RIGHTS OF PLAN**

To the full extent permitted by law, all rights and benefits under the Plan are exempt from attachment or garnishment or other legal process for the debts or liabilities of any Covered Person.

## **RIGHT TO ENFORCE PLAN PROVISIONS**

Failure by the Plan Sponsor or HealthSCOPE Benefits to enforce any provision of the Plan provision shall not affect the Plan Sponsor's or HealthSCOPE Benefits' right thereafter to enforce such provision or any other provisions of the Plan.

## **TERMINATION OF THE PLAN**

**Right to Terminate:** It is the intention of the Employer to continue this Plan indefinitely. However, the Plan Sponsor reserves the right to terminate this Plan at any time by an instrument duly executed by it.

**Effect of Termination:** Unless otherwise provided, upon the effective date of Plan termination, the Coverage of all Covered Persons shall cease and no person shall become entitled to any benefits hereunder for any expenses incurred after the effective date of Plan termination. The Plan shall remain liable to pay benefits for expenses incurred prior to the effective date of Plan termination, but only to the extent of the assets set aside for that purpose.

## **TITLES ARE FOR REFERENCE ONLY**

The titles used in the Plan are for reference only. In the event of a conflict between a title and the content of a Section, the content of the Section shall control.

## **WORD USAGE**

Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine or neuter form.

## **WORKERS' COMPENSATION COVERAGE**

The Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

## **OPERATION AND ADMINISTRATION OF THE PLAN**

### **PLAN SPONSOR AND PLAN ADMINISTRATOR**

The Plan is administered through the Conservation Employees' Benefits Plan Trust Fund which has been established and shall be maintained for the exclusive benefit of the employees. The Missouri Department of Conservation is the Employer and Plan Sponsor. The Conservation Employees' Benefits Plan Trust Fund, as the Plan Administrator, shall have full charge of the operation and management of the Plan. The Missouri Department of Conservation has retained the services of HealthSCOPE Benefits, Inc. ("HealthSCOPE Benefits"), a subsidiary of CenBen USA, Inc., to administer the benefits described in this Plan Document.

### **PLAN FIDUCIARY**

The Conservation Employees' Benefits Plan Trust Fund shall also function as the Plan Fiduciary unless the Missouri Department of Conservation appoints another individual or entity to act in this capacity. The Plan Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the Plan, to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary, including, but not limited to, the denial of certification of the Medical Necessity of Hospital or medical services, supplies and treatment, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Missouri Department of Conservation and the Conservation Employees' Benefits Plan Trust Fund will be final and binding on all interested parties. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

### **CLAIMS ADMINISTRATOR**

Under the Plan, HealthSCOPE Benefits, Inc. ("HealthSCOPE Benefits") has agreed to provide certain administrative services on behalf of the Conservation Employees' Benefits Plan Trust Fund according to the terms and limitations of the Plan. The responsibilities of HealthSCOPE Benefits are spelled out in an agreement between the Conservation Employees' Benefits Plan Trust Fund and HealthSCOPE Benefits ("Administrative Agreement") and include but are not limited to the administration of claims on behalf of the Conservation Employees' Benefits Plan Trust Fund. Claims for benefits under the Plan shall be filed, processed, reviewed, and, if denied, appealed in accordance with the procedures set forth in this Plan Document.

Except as otherwise provided by law, the appeal procedures set forth in this Plan Document shall be the sole and exclusive remedy.

HealthSCOPE Benefits does not furnish health care services and is not liable for the quality of health care services received by a Covered Person. HealthSCOPE Benefits does not provide insurance coverage or benefits nor does HealthSCOPE Benefits underwrite the liability of this Plan. HealthSCOPE Benefits will not act nor assume the responsibility to act as the Plan Administrator or Plan Fiduciary on behalf of the Plan Sponsor. HealthSCOPE Benefits is merely providing assistance with the administration of this Plan by adjudicating claims in accordance with the terms of the Plan.

### **DISCRETION**

Any discretion or judgment to be exercised by the Employer or its board of trustees shall be exercised in their sole and absolute discretion. If a member of the board of trustees must exercise his discretionary authority under this Plan with respect to himself as a Covered Employee in the Plan, then such discretionary authority shall be exercised solely and exclusively by a person designated by the other members of the board of trustees.

## **ADMINISTRATIVE DUTIES**

The Missouri Department of Conservation has appointed the Board of Trustees of the Conservation Employees' Benefits Plan Trust Fund to oversee the administration of the Plan on behalf of the Missouri Department of Conservation.

The following responsibilities shall be performed in the administration of the Plan. These duties may be performed by the Employer or by a committee of individuals appointed by the Employer to assist in the administration of the Plan:

1. Maintaining all Plan records;
2. Filing tax returns and reports required under federal and state law and complying with all other governmental reporting and disclosure requirements;
3. Authorizing payments and resolving questions concerning the Plan and interpreting, in its discretion, the Plan's provisions related to benefits and eligibility;
4. Hiring outside professionals to assist with Plan Administration and render advice concerning the responsibility they have under the Plan, including but not limited to hiring a claims administrator, actuaries, attorneys, accountants, brokers, consultants;
5. Establishing policies, interpretations, practices and procedures of the Plan;
6. Receiving all disclosures required of fiduciaries and other service providers under any federal or state law;
7. Acting as the Plan's agent for service of legal process;
8. Administering the Plan, including but not limited to the Plan's claims procedures as set forth in the Plan Document and the Plan Administrator's Plan Document;
9. Paying benefits under the Plan, by drawing checks, or instructing others to draw checks, against the Plan established for this purpose. With respect to claims that are administered by the claims administrator, HealthSCOPE Benefits, this responsibility includes instructing the claims administrator to withdraw monies from the funding account for the purpose of administering claims incurred under the Plan; and
10. Performing all other responsibilities allocated to the Plan Administrator.

## **DELEGATION OF RESPONSIBILITIES**

The Employer may delegate its responsibilities hereunder to other persons or entities. Such delegation shall be effective only if the proposed delegate executes an instrument acknowledging acceptance of the delegated responsibilities and only if delegation has been authorized by the Board of Trustees.

## **EMPLOYMENT OF ADVISERS**

The Employer or the Board of Trustees may employ third party administrators, such as the Claims Administrator, actuaries, attorneys, accountants, brokers, consultants, and other specialists to render advice concerning any responsibility they have under the Plan.

## **BONDING**

Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

## **WRITTEN DIRECTIONS**

Whenever a person must or may act upon the written direction of another, he shall not be required to inquire into the propriety of such direction, and he shall follow the direction unless it is clear on its face that the actions to be taken under that direction are prohibited by law or the terms of this Plan. Moreover, such person shall not be responsible for failure to act without such written direction.

## **RESOLUTIONS BY THE EMPLOYER**

All resolutions or other actions taken by the Employer that has been appointed to assist with the administration of the Plan at any meeting shall be handled as set forth in the Plan Document.

## **COMPENSATION OF CERTAIN EMPLOYEES**

Fiduciaries who are employees of the Employer shall not receive compensation under the Plan for services to the Plan; however, they may receive reimbursement for expenses actually incurred in the performance of such services.

## DEFINITIONS

**Actively Working/Actively At Work** - Means the employee is performing his/her regular duties on behalf of, and in the regular business of the Plan Sponsor for the hours as listed in the Eligibility and Effective Date of Coverage section and is reasonably being compensated by the Plan Sponsor on a regular basis for such duties.

**Administrative Agreement** - Means the contract between the Plan Sponsor and HealthSCOPE Benefits (HealthSCOPE Benefits) pursuant to which HealthSCOPE Benefits has been contracted to process claims on behalf of the Plan Sponsor.

**Alcoholism Treatment Facility** - Means a facility that is primarily engaged in the treatment of alcoholism. The facility must have in effect plans for utilization and peer review and programs for rehabilitation or rehabilitation and detoxification of alcoholism. The facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Health.

**Ambulatory Health Facility** - Means a facility which is organized and operated to provide medical care to Outpatients. The facility must provide preventive, diagnostic, therapeutic or rehabilitative services under the direction of a Physician. The facility must not be part of a Hospital.

**Ambulatory Surgical Facility** - Means a facility, with an organized staff of Physicians, which:

1. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
2. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
3. does not provide Inpatient accommodations; and
4. is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other Professional.

The facility must be accredited by the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Association.

**Benefit Period** – Means the period beginning on January 1<sup>st</sup> and ending on December 31<sup>st</sup> of each year.

**Cardiac Rehabilitation Therapy** - Means those Medically Necessary services that are rendered under the supervision of a Physician in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery. Therapy must be initiated within 12 weeks after the initial treatment for the medical condition ends and must be rendered in a Facility covered by the Plan.

**Certificate of Creditable Coverage** - Means a written document specifying the period of an employee's creditable coverage. Creditable coverage is credit for previous health coverage against the application of a pre-existing condition exclusion period when moving from one group health plan to another, from a group health plan to an individual policy, or from an individual policy to a group health plan. An individual will receive credit for previous coverage that occurred *without a break of 63 days or more*.

**Chiropractic Treatment** - Means treatment of the spine by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other Professional are required.

**Coinsurance** - Means a percentage of the Provider's Allowable Charge that the Plan pays for Eligible Expenses after the Covered Person's Deductible has been satisfied. The remaining percentage of the Provider's Allowable Charge will be paid by the Covered Person. This percentage of the Provider's Allowable Charge paid by the Covered Person is referred to as the Covered Person's Coinsurance.

**Community Mental Health Facility** - Means a facility that is primarily engaged in the treatment of mental illness, including substance abuse. The facility must have in effect utilization and peer review plans. The facility must also be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by the Department of Health.

**Confinement** - Means an Inpatient stay in a Hospital or other Facility. Two successive Confinements will be considered one Confinement if readmission is for the same or related condition for which the Covered Person was previously confined and the readmission occurs within 90 days.

**Copayment** - Means the dollar amount payable by the Covered Person for a service, treatment or procedure rendered. The Copayment is applicable on a per occurrence basis. The Copayment shall continue to apply after the Deductible has been satisfied and after the Out-of-Pocket Limit has been satisfied.

**Coverage** - Means the payment for Covered Services as specified and limited by this Plan Document.

**Covered Dependent Child(ren)** – Mean a Dependent Child(ren) who is/are covered under the Plan.

**Covered Employee** - Means the employee of the Employer who has satisfied the eligibility requirements under the Plan and is enrolled for Coverage under the Plan.

**Covered Persons** - Means the Covered Employee and, under Family Coverage, the Covered Employee's Covered Spouse and any unmarried Dependent Children who are eligible for Coverage.

**Covered Services** - Means services or supplies which are considered eligible for payment under this Plan.

**Covered Spouse** – Means a Spouse who is covered under the Plan.

**Creditable Coverage** - Means Coverage under any of the following:

1. Group health plan
2. Health insurance coverage, group or individual
3. Medicare
4. Medicaid
5. Medical and dental coverage for member and certain former members of Uniformed Services, and their dependents (Title 10 U.S.C. Chapter 55)
6. Medical care program of the Indian Health Services or a tribal organization
7. State health benefits risk pool;
8. Public health plan;
9. Federal Employees Health Benefits Program
10. Health benefit plan under Peace Corps Act
11. State Children's Health Insurance Program

**Customary and Reasonable Charge**– Means the maximum amount of charges for Covered Services (other than Outpatient Dialysis Covered Services) upon which benefit payment determinations will be based in connection with Covered Services rendered by a Non-Preferred Provider. The Customary and Reasonable fee is the fee assessed by a Non-Preferred Provider for a service, treatment or supply which shall not exceed the general level of charges assessed by Providers rendering the same type of service, treatment or supplies. The Customary and Reasonable fee is established using historical data collected for charges by Providers within specific geographic areas for the same or similar services, treatment or supplies. The data may be supplemented with information provided by independent research firms who specialize in the collection of

Provider charge data. Unusual circumstances that reasonably require additional time, skill or experience for a Provider's service, are taken into consideration by the Plan and may result in reimbursement of an amount above the Customary and Reasonable maximum but not exceeding the actual charge. The Customary and Reasonable charge does not apply to Preferred Providers and does not apply to charges in connection with Outpatient Dialysis Covered Services.

**Deductible** - Means the amount a Covered Person must pay for Eligible Expenses incurred in a Benefit Period before benefits begin to be paid for that person under the Plan.

When applicable, an Individual Deductible is the amount that each Covered Person must pay during a Benefit Period before benefits begin to be paid for that person.

A Family Deductible is the maximum amount that two (2) or more family members covered under the same Family Coverage must pay in Deductible expense in a Benefit Period. Under the Family Deductible, at least two (2) family members must satisfy an amount equal to the Individual Deductible, while Eligible Expenses for all other family members will be used to satisfy the remaining portion of the Family Deductible. Once the Family Deductible is reached, Eligible Expenses incurred with a future date of service within the Benefit Period will not be subject to the Deductible and the Deductible will be considered satisfied for all family members under that Family Coverage during the remainder of the Benefit Period.

**Dependent** - Means a Dependent Child or Spouse.

**Dependent Child** - Means one of the following:

1. an employee's child who is less than 26 years of age; or
2. An employee's child, regardless of age, who was continuously covered prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his or her own living. Such child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the child attains the limiting age under the bullets above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

1. **Dependent Limiting Age** – Means the date on which the child attains the age of 26.2z

**Diagnostic Services** - Means tests and procedures performed when the Covered Person has specific symptoms to detect or to monitor the Covered Person's disease or condition. Diagnostic Services include, but are not limited to, the following: X-ray and other radiology services; laboratory and pathology services; cardiographic, encephalographic and radioisotope tests.

**Effective Date** - Means the date on which Coverage begins.

**Eligible Employee** – Means an employee of the Employer who satisfies the eligibility criteria set forth in this Plan Document.

**Eligible Expenses** - Means expenses for Covered Services which are incurred by a Covered Person. Eligible Expenses do not include expenses in excess of the Provider's Allowable Charge.

**Emergency Care** - Means care and treatment provided in the Outpatient emergency department of a Hospital or Other Medical Facility Provider within 72 hours of the onset of the Illness or occurrence of the Injury.

**Emergency Medical Condition** - Means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge

of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

**Emergency Services** - Means, with respect to an Emergency Medical Condition: a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

**Enrollment Date** - Means the first day of coverage, or if there is a waiting period, the first day of the waiting period. As used in this definition, the waiting period means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the Plan can become effective. This definition replaces any other definition that appears in your current Plan Document.

**Essential Health Benefits** - Means, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; Maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Experimental or Investigative** - Means the use of any procedure, treatment, facility, equipment, drug, device or supply which is not approved or accepted as standard medical treatment of the condition being treated or any such item requiring American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, U.S. Food and Drug Administration, National Institute of Health, American Dental Association or American Osteopathic Association or other government approval, if it is not granted at the time services are rendered. In determining whether any treatment, procedure, facility, equipment, drug, device or supply is Experimental or Investigative, the Plan Administrator may consider the views of the state or national medical communities and the views and practices of Medicare, Medicaid and other government financed programs. Although a Physician may have prescribed treatment, such treatment may still be considered Experimental or Investigative within this definition.

**Family Coverage** - Means Coverage for the Covered Employee and one or more Dependents.

**GINA** – Means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term “genetic information” means, with respect to any individual, information about:

- Such individual’s genetic tests;
- The genetic tests of family members of such individual; and
- The manifestation of a disease or disorder in family members of such individual.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes.

Therefore, this Plan will not discriminate in any manner with its Participants on the basis of such genetic information.

**HMO Network** – Means the network of Preferred Providers to which the Covered Persons will have access under this Plan.

**Health Plan (also Plan)** - Means a self funded health coverage program provided and sponsored by the Plan Sponsor.

**Home Health Care Provider** - Means a facility which provides skilled nursing and other services on a visiting basis in the Covered Person's home, and is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician. A Home Health Care Provider must be certified by Medicare or accredited by the Joint Commission on the Accreditation of Health Care Organizations.

**Hospice Provider** - Means a facility that provides medical, social, psychological and spiritual care as palliative treatment for terminally ill patients in the home and/or as an Inpatient using an interdisciplinary team of professionals. A Hospice Provider must be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by Medicare.

**Hospital** - Means an institution licensed by the jurisdiction in which it is located; approved by the Joint Commission on the Accreditation of the Health Care Organizations or certified under Medicare. It must provide Inpatient medical care and treatment, a staff of physicians and nurses, facilities for diagnosis and major surgery, but cannot be mainly a place for the aged or for treatment of alcoholism or drug addiction.

**Illness** - Means any physical disease or mental illness. Pregnancy, premature birth, congenital anomalies and birth anomalies are considered to be Illnesses.

**In-Network** - Refers to Covered Services rendered by a Preferred Provider in the HMO Network or PPO Network.

**Individual Coverage** - Means Coverage for the Covered Employee only.

**Inhalation Therapy** – Means a type of therapy that involves the introduction of dry or moist gases into the lungs.

**Injury** - Means an accidental bodily injury caused by external and violent means. Injury to the teeth as a result of biting and chewing is not considered an accidental bodily Injury.

**Inpatient** - Means a Covered Person who is admitted to a Hospital or Other Medical Facility Provider as a registered Inpatient and who remains in the Hospital or Other Medical Facility Provider for 24 or more consecutive hours.

**Laboratory** - Means a facility which is maintained to perform diagnostic tests and which is approved for Medicare reimbursement.

**Limitation for Covered Person's Expenses** - Means the maximum amount in Eligible Expenses that are paid at the Coinsurance level as shown in the Schedule of Benefits. Eligible Expenses are payable at the Coinsurance percentages shown in the Schedule of Benefits until the Covered Person has reached the Individual Limitation for Covered Persons Expenses, also shown in the Schedule of Benefits. Once the Covered Person has reached the Individual Limitation for Covered Persons Expenses, Eligible Expenses will be payable at 100% (except for any charges excluded) for the remainder of the Benefit Period.

When the Family Limitation for Covered Persons Expenses is met, Eligible Expenses will be payable at 100% (except for any charges excluded) for the remainder of the Benefit Period for all covered members of the same family.

**Loss of Eligibility** – As it relates to a Special Enrollment Period, Loss of Eligibility includes but is not limited to the following types of losses:

1. Loss of eligibility under the other coverage due to divorce, dissolution, legal separation. In this instance, the Eligible Employee and any Dependent Children would be eligible to enroll;
2. Loss of eligibility under the other coverage due to cessation of dependency status. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll;
3. Loss of eligibility under the other coverage due to death of the employee. In this instance, the Eligible Employee (whose spouse has died) and any Dependent Children would be eligible to enroll;
4. Loss of eligibility under the other coverage due to termination of employment or reduction of hours. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll;
5. Loss of eligibility under the other coverage because the individual no longer resides in the service area. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll;
6. Loss of eligibility under the other coverage because the overall maximum benefit has been reached. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll;
7. Loss of eligibility under the other coverage because the other employer ceases to provide health care benefits to similarly situated individuals. In this instance, the Eligible Employee, Spouse, and any Dependent Children would be eligible to enroll.

**Maternity Services** - Means services for normal pregnancy, complications of pregnancy and miscarriage.

**Maximum Benefit** – Means the maximum amount the Plan will pay for a given benefit. The Maximum Benefit can be stated as a dollar amount or the maximum number of days or visits for a specific benefit. Refer to the Schedule of Benefits for maximum benefit amounts.

**Medical Benefits** Means the medical Covered Services described in the section entitled “Medical Benefits” and the payment made by the Plan for such services as set forth in this Plan Document.

**Medically Necessary (or Medical Necessity)** - Means the criteria used to determine the Medical Necessity of Covered Services under this Plan Document.

To be Medically Necessary, Covered Services must:

1. Be rendered in connection with an Injury or Illness;
2. Be consistent with the diagnosis and treatment of the Covered Person’s condition;
3. Be in accordance with the standards of good medical practice;
4. Not be considered Experimental or Investigative; and
5. Not be for the Covered Person’s convenience or the convenience of the Covered Person’s Physician.

To be Medically Necessary, Covered Services must also be provided at the most appropriate level of care or in the most appropriate type of health care facility. Only the Covered Person’s medical condition (not the financial status or family situation, the distance from a Facility or any other non-medical factor) is considered in determining which level of care or type of health care facility is appropriate.

In order for Covered Services to be paid, the services must be Medically Necessary. Any service failing to meet the Medical Necessity criteria may be the Covered Employee's liability.

**Medically Necessary Leave of Absence** - A Leave of Absence by a full-time student Dependent in a postsecondary education institution that:

- Commences while such Dependent is suffering from a serious Illness or Injury;
- Is Medically Necessary; and

- Causes such Dependent to lose student status at a postsecondary educational institution for purposes of coverage under the terms of the Plan.

**Medicare** - Means the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

**Negotiated Rate** – Means the rate established by the contract in effect between the HMO Network and the Preferred Provider, or the PPO Network and the Preferred Provider. Under this contract, the Preferred Provider has agreed to accept a reduced rate (“Negotiated Rate”) as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate.

**Network Service Area** – Means the geographical area in which Preferred Providers are located and that services the Covered Persons under this Plan.

**Non-Preferred Provider** - Means a Provider who is not participating in the HMO Network or PPO Network.

**Nutritional Counseling** - A type of assessment made which analyzes various health needs in regard to diet and exercise. A nutritional counselor helps people to set achievable health goals and teaches various ways of maintaining these goals throughout their lifetime. The nutritional counselor provides information based on a person’s current status, helping to improve overall health.

**Occupational Therapy** - Means treatment rendered on an Inpatient or Outpatient basis as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts).

**Ophthalmologist** - Means a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.) legally qualified to practice medicine, including diagnosis, treatment and prescribing of medications and lenses related to conditions of the eye.

**Other Benefit Plan** - Refers to Coordination of Benefits (COB) and means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trustee plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

**Out-of-Network** - Refers to Covered Services rendered by a Non-Preferred Provider.

**Outpatient** - Means a Covered Person who receives medical care or treatment when he or she is not an Inpatient.

**Partial Day Treatment Program (or Partial Day Treatment)** - Means a psychiatric and/or substance abuse program, involving Covered Services, which is accredited by the Joint Commission of Accreditation of Health Care Organizations or is in compliance with equivalent standards for patients who require skilled level of care in a Hospital or Other Medical Facility Provider but who do not need treatment for an acute or life threatening condition. A Partial Day Treatment Program is provided in a treatment setting that is less than a 24-hour residential setting.

**Pharmacy** - Means a facility which is a licensed establishment where prescription drugs are dispensed by a pharmacist under applicable state laws.

**Physical Therapy** - Means treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore

maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other Professional are required.

**Physician** - Means one of these professionals licensed under the applicable state laws:

1. Doctor of Medicine (M.D.);
2. Doctor of Osteopathy (D.O.);
3. Podiatrist (D.P.M.) or Surgical Chiropodist (D.S.C.);
4. Dental Surgeon or Dentist (D.D.S.);
5. Chiropractor (D.C.);
6. Doctor of Optometry (O.D.);
7. Psychiatrist;
8. Psychologist; and
9. Ophthalmologist.

**Plan Administrator** – Means the person designated to administer the Plan and whose responsibilities are set forth in the section of the Plan Document entitled “Operation and Administration of the Plan.”

**Plan Document** - Means the written document, as adopted by the Plan Administrator, that sets forth the Plan’s terms and conditions. This document is the Plan Document.

**Plan Fiduciary** – Means the Employer or person designated by the Employer to act as the Plan Fiduciary. The Plan Fiduciary is identified and designated in the section entitled “Operation and Administration of the Plan.”

**Plan Sponsor** – Means the entity designated to sponsor the Plan. The Plan Sponsor is identified and designated in the section of the Plan Document entitled “Operation and Administration of the Plan.”

**PPO Network** – Means the network of Preferred Providers to which the Covered Persons will have access under this Plan.

**Pre-certification** – Means a determination of Medical Necessity of the services or procedures and the appropriateness of the planned course of treatment (e.g., appropriate length of stay or the appropriate number of visits or treatments). Compliance with the pre-certification and notification requirements is not a guarantee of benefit payment.

**Pre-Existing Condition** - Means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period ending on the Covered Person's Enrollment Date. A pregnancy is not considered a Pre-Existing Condition.

**Pre-Existing Condition Waiting Period** - Means the waiting period in connection with a Pre-Existing Condition as set forth in this Plan.

**Preferred Provider** - Means a Provider who is a member of the HMO Network or PPO Network.

**Prescription Drug Benefits** - Means the Covered Services for prescription drugs obtained from a Pharmacy and/or Mail Order Drug Company as described in the section entitled “Prescription Drug Benefits” and the payment made by the Plan for such services as set forth in this Plan Document.

**Primary Care Physician (PCP)** – Means a Physician in family medicine, general medicine, internal medicine, pediatrics, and obstetrics and gynecology.

**Prior Authorization** – Means authorization obtained by a Covered Person prior to obtaining or purchasing a prescription drug. The Covered Person must obtain Prior Authorization for any Covered Drug which costs more than \$1,000. Additionally, a Covered Person may obtain Prior Authorization for drugs which are not included in the “Covered Prescription Drugs” section. If Prior Authorization is obtained for drugs which are not included under the “Covered Prescription Drugs” section, such medications shall be covered as an Eligible Expense under the Plan. The Plan will also provide Coverage for prescriptions obtained from a Non-Participating Pharmacy when Prior Authorization is obtained in accordance with the provisions set forth herein.

In order to obtain Prior Authorization, the Covered Person should contact the Prescription Drug Vendor at the phone number appearing on the Covered Person’s identification card prior to obtaining or purchasing the prescription drug. The Covered Person may be asked to provide certain information to assist in the determination of a drug’s Medical Necessity. Failure to obtain Prior Authorization for the drugs listed within this section will result in **no Coverage** for such drugs under the Plan.

**Protected Health Information** - Means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Personal health information includes information of persons living or deceased. The following components of a member's information also are considered personal health information: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and, o) any other unique identifying number, characteristic, or code. Protected Health Information includes Electronic Protected Health Information as defined at 45 C.F.R. §160.103 that is received from, or created or received on behalf of the Plan.

**Provider** - Means for Medical Benefits, the Facility Providers or Professional Providers listed below which are licensed and are operating within the scope of that license:

**Facility Provider** – Means a Hospital and an Other Medical Facility.

**Other Medical Facility** - Means a Facility Provider other than a Hospital and includes the following:

1. Ambulatory Health Facility;
2. Ambulatory Surgical Facility;
3. Home Health Care Provider;
4. Hospice Provider;
5. Skilled Nursing Facility;
6. Community Mental Health Facility;
7. Alcoholism Treatment Facility; and
8. Specialized Hospital.

**Professional Provider** – Means a Physician and an Other Medical Professional.

**Other Medical Professional** - Means a Professional Provider other than a Physician and includes the following:

1. Physical Therapist;
2. Speech Therapist;
3. Registered Nurse Anesthetist (C.R.N.A.);
4. Registered Nurse (R.N.);
5. Licensed Practical Nurse (L.P.N.);
6. Licensed Occupational Therapist (O.T.);
7. Pharmacy;
8. Certified Nurse Midwife (C.N.M.);
9. Laboratory (must be Medicare approved);
10. Professional Ambulance Service; and
11. Licensed Social Worker.
12. Nutritionist.

**Provider's Allowable Charge** – Means the method used by the Plan for determining the maximum amount of charges to consider in determining benefit payments under the Plan. Payment will be subject to any applicable Deductible, Coinsurance and other applicable Plan provisions; the Plan will determine the Provider's Allowable Charge for all Providers. With respect to the Preferred Providers, the Provider's Allowable Charge will be based on the Negotiated Rate set forth in the PPO contract. For Non-Preferred Providers, the Provider's Allowable Charge will be the Customary and Reasonable Charge.

**Qualified Medical Dependent Child Support Order (QMCSO)** – Means a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan. An Eligible Employee may obtain a copy of such procedures from the Plan Sponsor.

**Rehabilitation Facility** – Means a facility that is primarily engaged in the Inpatient treatment and rehabilitation of the Covered Person as the result of an acute Illness or Injury, not including the rehabilitation of a condition resulting from substance abuse. The facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Health.

**Schedule of Benefits** - Means a separate schedule showing vital information with respect to the Coverage under this Plan.

**Significant Break** - Means a period of 63 consecutive days during each of which the individual does not have creditable coverage.

**Skilled Nursing Facility** - Means a facility which mainly provides Inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal custodial care, ambulatory or part time care or that provides treatment for mental illness, alcoholism, drug abuse or tuberculosis. The Skilled Nursing Facility must be certified by the Medicare program.

**Special Enrollment Period** – Means a period during which an enrollment application may be submitted following an event that qualifies the Eligible Employee or Eligible Dependent for a Special Enrollment Period. The events that qualify an Eligible Employee or an Eligible Dependent for a Special Enrollment Period and the time periods during which an Enrollment Application must be submitted during such period is addressed in the section entitled Applying for Coverage and Effective Dates.

**Specialist** – A Physician other than a Primary Care Physician.

**Specialized Hospital** - Means a facility that is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must also be provided under the supervision of a registered nurse.

**Speech Therapy** - Means active treatment for the correction of a speech impairment resulting from a disease, surgery, injury, congenital or developmental anomalies, or for previous therapeutic processes. Treatment must be Medically Necessary, ordered by a Physician, and either post-operative or for the convalescent stage of an active illness or disease.

**Spouse** – Means an individual of the opposite sex who is legally married to the Eligible Employee in accordance with the laws of the state in which they reside. As used herein, “Spouse” does not include a domestic partner. The Plan does not recognize common law marriages. For eligibility purposes, the Plan Administrator may require documentation proving a legal marital relationship.

**Summary Health Information** - Means information, that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

**Summary Plan Description** – Means a summary of the Plan’s terms that must be furnished to a Covered Employee. This summary is included in this Plan Document.

**Surviving Dependent Child** – Means the Dependent Child of a deceased employee who was covered under the Plan on the date of death.

**Surviving Spouse** – Means the Spouse of a deceased employee who was covered under the Plan on the date of death.

**Waiting Period** – Means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the Plan can become effective.

## **PLAN INFORMATION**

**1. NAME OF THE PLAN**

The Conservation Employees' Benefits Plan Trust Fund

**2. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN SPONSOR**

The Missouri Department of Conservation  
2901 W. Truman Blvd., Jefferson City, Missouri 65109  
P.O. Box 180, Jefferson City, Missouri 65102-0180  
(573) 751-4115

**3. PLAN SPONSOR IDENTIFICATION NUMBER**

43-1870797

**4. PLAN NUMBER**

501

**5. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR**

The Conservation Employees' Benefits Plan Trust Fund  
2901 W. Truman Blvd., Jefferson City, Missouri 65109  
P.O. Box 570, Jefferson City, Missouri 65102-0570  
(573) 751-4115

**6. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PERSON DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS**

The Conservation Employees' Benefits Plan Trust Fund  
2901 W. Truman Blvd., Jefferson City, Missouri 65109  
P.O. Box 180, Jefferson City, Missouri 65102-0180  
(573) 751-4115

**7. PLAN YEAR (for fiscal record keeping)**

January 1<sup>st</sup> through 12:00 a.m. on December 31<sup>st</sup>

**8. CLAIMS ADMINISTRATOR**

HealthSCOPE Benefits  
27 Corporate Hill Drive  
Little Rock, Arkansas 72205  
501-225-1551

Send Non-PPO Claims to:  
HealthSCOPE Benefits  
P. O. Box 99006  
Lubbock, TX 79490-9006

Send PPO Claims to the PPO Network(s) appearing on the identification card.  
Send Prescription Drug Claims to the Prescription Drug Vendor appearing on the identification card.

**9. UTILIZATION REVIEW ADMINISTRATOR**

HealthLink  
P.O. Box 419104  
St. Louis, MO 63141

**10. ADDRESS AND TELEPHONE NUMBER OF THE OFFICE OF THE DEPARTMENT OF LABOR**

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, N.W.  
Room N-5644  
Washington, D.C. 20210  
(202) 565-7500

**11. EFFECTIVE DATE OF THE PLAN**

The effective date of the Plan is January 1, 2000. The Plan is amended and restated effective January 1, 2011.

**12. TYPE OF PLAN**

Group health benefits which include medical and prescription drug benefits. Health benefits are provided primarily by the Employer with claims being paid on behalf of the Employer by the Claims Administrator from the Plan's assets. Contributions for these benefits are also made in part by employees.

**13. TYPE OF ADMINISTRATION**

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Administrator to provide claims payment and ministerial administration.

**14. SOURCES OF CONTRIBUTIONS**

Contributions for Plan expenses are obtained from the Employer and from the participating employees. The Employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the Employer and the amount to be contributed by the participating employees.

## **SPECIAL NOTICES**

### **NOTICE CONCERNING RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)**

Group health plans and issuers are required to provide Coverage for the following services to an individual receiving benefits in connection with a covered mastectomy:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan is required to notify the Covered Person of his or her WHCRA rights each year.

### **NOTICE CONCERNING RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996**

Group health plans and issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the group health plan or issuer may pay for a shorter stay if the attending Provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or issuer may not, under federal law, require a Physician or other health care Provider to obtain authorization for prescribing a length of stay of up to 48 or 96-hours.

### **NOTICE REGARDING YOUR RIGHTS UPON TERMINATION OF COVERAGE**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all persons who lose Coverage under an employer group health Plan be automatically provided with a HIPAA Certificate of Creditable Coverage ("HIPAA Certificate"). The covered employee will need a HIPAA Certificate if (s)he enrolls in another employer group health plan that contains a Pre-Existing Condition Waiting Period.

HIPAA also requires that a HIPAA Certificate be provided upon request to the employer (1) at any time while the employee is covered under the Plan and (2) within 24 months after the date that Coverage ended, regardless of whether a HIPAA Certificate was issued automatically at the time of termination. If the covered employee requests a HIPAA Certificate before losing the Coverage, the HIPAA Certificate will describe the length of Coverage, but will indicate that no Coverage has been lost.

HIPAA Certificates must also be provided to persons who would have lost Coverage if not for the election of COBRA Continuation Coverage. In this event, the COBRA beneficiary will receive two automatic HIPAA Certificates, one upon the initial qualifying event, and another when COBRA Continuation Coverage ends.

A HIPAA Certificate must include all of the following:

1. Date that the HIPAA Certificate was issued;
2. Name of the Plan that provided Coverage;
3. Name of the covered employee and/or dependents to whom the HIPAA Certificate applies, along with any information necessary for the Plan specified in the HIPAA Certificate to identify such person(s) (name or ID number);
4. Name, address, and telephone number of the Plan Administrator required to provide the HIPAA Certificate; and
5. Telephone number to call for further information regarding the HIPAA Certificate.

The employer is required to provide the employee with written procedures on how to request a HIPAA Certificate. Therefore, the employee may contact his or her employer to obtain additional information concerning requesting a HIPAA Certificate.

<p style="text-align: center;"><b>NOTICE CONCERNING THE HIPAA PRIVACY AND SECURITY REGULATION</b></p>
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1. **Permitted and Required Uses and Disclosure of Protected Health Information.** Subject to obtaining written certification pursuant to paragraph 3 (below) of the Plan, the Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Protected Health Information to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such Protected Health Information except for the following purposes:
  - a. To perform Plan administrative functions which the Plan Sponsor performs for the Plan.
  - b. Obtaining premium bids from insurance companies, HMOs or other health plans for providing health insurance coverage under the group health plan; or
  - c. Modifying, amending, or terminating the group health plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

2. **Conditions of Disclosure.** The Plan or a health insurance issuer or HMO with respect to the Plan, shall not disclose Protected Health Information to the Plan Sponsor unless the Plan Sponsor agrees to:
  - a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.
  - b. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information, including implementing reasonable and appropriate security measures to protect Electronic Protected Health Information.
  - c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
  - d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
  - e. Make available to a Plan participant who requests access the Plan participant's Protected Health Information in accordance with 45 CFR §164.524.

- f. Make available to a Plan participant who requests an amendment the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with 45 CFR §164.526.
  - g. Make available to a Plan participant who request an accounting of disclosures of the participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
  - h. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR §164.504(f).
  - i. If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.
  - j. Ensure that the adequate separation between Plan and Plan Sponsor required in 45 CFR §164.504(f)(2)(iii) is satisfied, including ensuring reasonable and appropriate security measures.
  - k. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.
  - l. Report to the Plan any security incident relating to Electronic Protected Health Information of which it becomes aware. A security incident is defined at 45 C.F.R. §164.304 as "the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system."
3. **Certification of Plan Sponsor.** The Plan shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 2 of this section as contained in the Plan Document.
  4. **Permitted Uses and Disclosure of Summary Health Information.** The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:
    - a. Obtaining premium bids from health plan providers for providing health insurance coverage under the Plan; or
    - b. Modifying, amending, or terminating the Plan.
  5. **Permitted Uses and Disclosure of Enrollment and Disenrollment Information.** The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the Plan Sponsor, provided such enrollment and disenrollment information is only used by the Plan Sponsor for the purpose of performing administrative functions that the Plan Sponsor performs for the Plan.
  6. **Adequate Separation Between Plan and Plan Sponsor.** The Plan Sponsor shall only allow certain employees or classes of employees access to the Protected Health Information. Such employees shall only have access to and use such Protected Health Information to the extent necessary to perform the administration functions that the Plan Sponsor performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

The employees or classes of employees that will be permitted access to Protected Health Information as set forth in this paragraph are: the Human Resources Specialist; the Human Resources Technician; the Compensation & Benefits Manager; the Human Resources Analyst; and the Human Resources Data Analyst.

**Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions**

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Notify Participants of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18); and
2. Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 18).

**COMPLIANCE WITH FEDERAL LAWS**

The terms of this Plan will be construed and administered to meet the minimum requirements of applicable federal laws, including the Consolidated Omnibus Budget Reconciliation Act of 1985(COBRA), the 2009 American Recovery and Reinvestment Act (ARRA), Employee Retirement Income Act of 1974 (ERISA), the Americans with Disabilities Act of 1990 (ADA), the Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009, the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Mental Health Parity Act of 1996, the Newborns and Mothers Health Protection Act of 1996, and the Women’s Health and Cancer Rights Act of 1998, Genetic Information Nondiscrimination Act of 2008 (GINA), Michelle’s Law. To the extent a Plan provision is contrary to or fails to address the minimum requirements of an applicable federal law, this Plan shall provide the coverage or benefit necessary to comply with such minimum requirements.